EXECUTIVE SUMMARY

Community Mental Health Services Block Grant Application for FFY 2006 Funds

This document contains Kentucky's plans for State Fiscal Year 2006 to strengthen mental health services for adults with severe mental illnesses and children with severe emotional disturbances. It is submitted in compliance with P. L. 102-321, the Community Mental Health Services (CMHS) Block Grant, and applies for funds that will become available in Federal Fiscal Year 2006.

CMHS Block Grant funds will only be used to carry out the activities identified in the state's approved plan; to evaluate programs under the plan; and to plan, administer and educate stakeholders regarding services under the plan. Most of the CMHS Block Grant funds are allocated to Kentucky's Regional Mental Health and Mental Retardation Boards. Federal limitations on administrative costs are met. CMHS requires that a certain percentage of the state's CMHS Block Grant allocation be set aside for children's services, and Kentucky exceeds that minimum.

The plans required by the block grant must address all activities that build systems of care for adults with severe mental illnesses and children with severe emotional disturbances, not just those supported by CMHS Block Grant funds (which represent about 3 percent of community mental health revenues). Therefore, in some important ways, our application for the funds drives the development of stronger services using all funding sources, including Medicaid, local funds, and appropriations from the Kentucky General Assembly.

The planning process required by the federal agency also gives us an opportunity to present it for formal review by a panel of stakeholders, the Kentucky Mental Health Services Planning Council. Parents, family members, and consumers are well represented on the Council, and we believe that the state's plan is stronger because of their involvement, ideas, and comments.

As a result of major statewide planning initiatives prompted by the Kentucky General Assembly including the *Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders and Dual Diagnoses* (HB 843 Commission), Regional MH/MR Boards are allocated flexible funding on a per capita basis for planning and development of systems of care that are responsive to regional and local conditions. In return for this flexibility, Regional Boards are required to:

- Establish a parallel planning council at the regional level;
- Submit a comprehensive regional plan to develop systems of care for the priority populations;
- Submit a detailed spending plan;
- Set performance targets; and
- Submit data related to performance indicators and clinical outcomes established by the Department and the Planning Council, and the National Outcomes Measures and Uniform Data Tables established by CMHS.

Further detail about the block grant allocation methodology is provided in Sections I and II of the plan document. The following major program initiatives for the target populations are planned for SFY 2006.

For Adults with Severe Mental Illnesses:

- Assist Regional MH/MR Boards and local jails in the development, implementation and monitoring of behavioral health jail telephonic triage system;
- Assure the development of Memorandums of Agreement between state operated/state contracted hospitals and Regional MH/MR Boards;
- Evaluate and adapt the Crisis Stabilization Program system to effectively serve individuals with co-occurring disabilities;
- Implement the next phase of the adult outcome initiative that will measure consumer satisfaction as well as clinical outcomes;
- Continue to transition long-term residents of state psychiatric hospitals to the community using available wraparound funding;
- Explore alternative, cost effective methods for administering the Community Medications Support Program; and
- Promote best practices as a standard for service delivery.

For Children with Severe Emotional Disturbances:

- Promote consumer and family involvement at every level of the children's system of care;
- Initiate implementation of the newly revised Kentucky IMPACT Outcomes Measurement System;
- Partner with Regional Boards to promote best practices and share information among stakeholders;
- Partner with the Kentucky Center for Instructional Discipline to provide statewide training and technical assistance to Regional MH/MR Board staff and local education authorities in implementing components of the three-tiered , strengths-based model - Positive Behavioral Interventions and Supports (PBIS), to address mental health needs of children in school settings;
- Establish interagency collaboration (State Interagency Council and Department of Education) to address the transition needs of children with disabilities;
- Support the establishment of a sustainable suicide prevention effort, focusing on basic skills for educational staff;
- Develop Case Management Standards of Care in collaboration with DMHMRS, SIAC partners, Regional Boards, and youth/families.
- Establish statewide system for measuring client satisfaction.

A Note on Fiscal Years

This document describes activities and plans that span several years. In addition, state and federal fiscal years, which are different, may be applicable to certain plans and reports. This note explains their usage.

The State Fiscal Year (SFY) begins July 1 of the preceding year and ends on June 30 of the year (e.g., SFY 2006 is the period July 1, 2005 to June 30, 2006). The Federal

Fiscal Year (FFY) begins October 1 of the preceding year and ends on September 30 of the year (e.g., FFY 2006 is the period October 1, 2005 to September 30, 2006).

To contract federal funds received through the CMHS block grant in an appropriate and planned way, funds received by KDMHMRS for the federal fiscal year are typically expended during the following state fiscal year. This document supports an application for FFY 2006 funds, which will be spent during SFY 2007. However, to plan for and report on federal fund expenditures in real time, this document reports on the state fiscal year just ending (SFY 2005) and makes plans for the state fiscal year that is beginning (SFY 2006).

In this document:

Achievements will be reported for the year ending, which is	SFY 2005
Plans for the coming year will be described for	SFY 2006
Federal funds will be **requested** for	FFY 2006
FFY 2006 federal funds will be **expended** in part during	SFY 2007

Table of Contents

Section I: Description of the State Service System

This section provides background for understanding how Kentucky provides mental health services, and the major activities and issues that currently affect the planning environment. Section II, which follows this section, provides more detailed information about the context for planning services for adults with severe mental illness (SMI) and children with severe emotional disabilities (SED).

The discussion of this section is organized as follows:

- State Mental Health Authority
- Recent Challenges and Achievements
- System Change Activities
- Legislative Initiatives
- State Service Delivery System
- Community Mental Health Funding
- Coordination of Mental Health Care
- Mental Health Services Planning Council

State Mental Health Authority

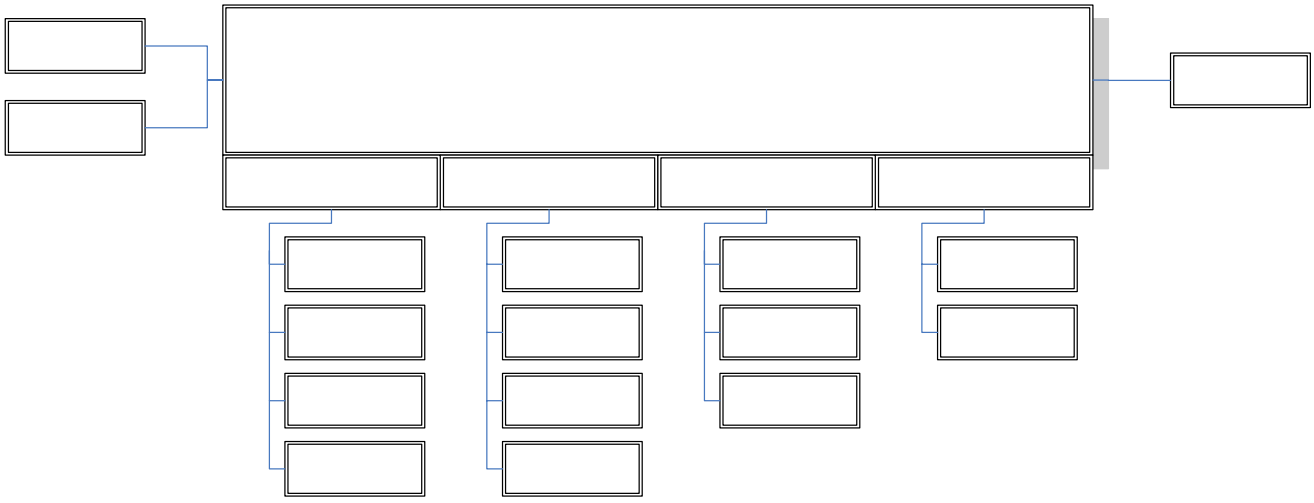
Kentucky's Mental Health Authority is the Department for Mental Health and Mental Retardation Services (KDMHMRS), which has responsibility for these service systems:

- Mental Health
- Mental Retardation
- Substance Abuse
- Brain Injury

KDMHMRS is part of the Cabinet for Health and Family Services, which is also the umbrella organization for these agencies (among other offices and councils):

- Department for Community-Based Services (Child and Adult Protection)
- Department for Public Health (Local and State Health Programs)
- Department for Medicaid Services (Medicaid Authority)
- Department for Human Support Services (Aging, Child Abuse and Domestic Violence Services)

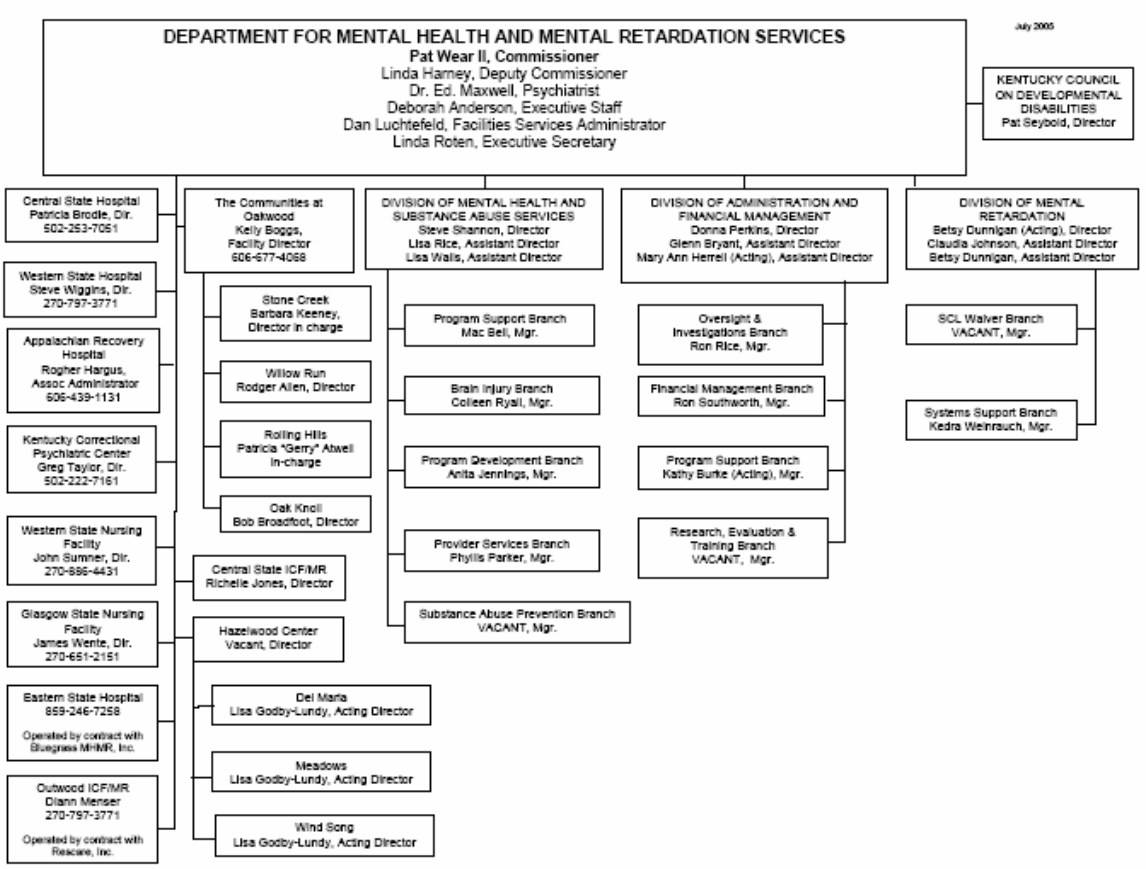
The following two pages show the most recent organizational charts for the Cabinet for Health and Family Services and the Department for Mental Health and Mental Retardation Services.



Office of Legal Services
53-721-01

Office of the Inspector General
53-723

Underse


DEPARTMENT FOR MENTAL HEALTH AND MENTAL RETARDATION SERVICES
Pat Wear II, Commissioner
Linda Harney, Deputy Commissioner
Dr. Ed. Maxwell, Psychiatrist
Deborah Anderson, Executive Staff
Dan Luchtefeld, Facilities Services Administrator
Linda Roten, Executive Secretary
July 2005
KENTUCKY COUNCIL ON DEVELOPMENTAL DISABILITIES
Pat Seybold, Director
Central State Hospital
Patricia Brodie, Dir.
502-253-7051
Western State Hospital
Steve Wiggins, Dir.
270-797-3771
Appalachian Recovery Hospital
Rogher Hargus,
Assoc Administrator
606-439-1131
Kentucky Correctional Psychiatric Center
Greg Taylor, Dir.
502-222-7161
Western State Nursing Facility
John Sumner, Dir.
270-886-4431
Glasgow State Nursing Facility
James Wente, Dir.
270-651-2151
Eastern State Hospital
859-246-7258
Operated by contract with Bluegrass MHMR, Inc.
Outwood ICF/MR
Diann Menser
270-797-3771
Operated by contract with Rescare, Inc.
The Communities at Oakwood
Kelly Boggs,
Facility Director
606-677-4068
Stone Creek
Barbara Keeney,
Director in charge
Willow Run
Rodger Allen, Director
Rolling Hills
Patricia "Gerry" Atwell
In-charge
Oak Knoll
Bob Broadfoot, Director
Central State ICF/MR
Richelle Jones, Director
Hazelwood Center
Vacant, Director
Del Maria
Lisa Godby-Lundy, Acting Director
Meadows
Lisa Godby-Lundy, Acting Director
Wind Song
Lisa Godby-Lundy, Acting Director
DIVISION OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
Steve Shannon, Director
Lisa Rice, Assistant Director
Lisa Walls, Assistant Director
Program Support Branch
Mac Bell, Mgr.
Brain Injury Branch
Colleen Ryall, Mgr.
Program Development Branch
Anita Jennings, Mgr.
Provider Services Branch
Phyllis Parker, Mgr.
Substance Abuse Prevention Branch
VACANT, Mgr.
DIVISION OF ADMINISTRATION AND FINANCIAL MANAGEMENT
Donna Perkins, Director
Glenn Bryant, Assistant Director
Mary Ann Herrell (Acting), Assistant Director
Oversight & Investigations Branch
Ron Rice, Mgr.
Financial Management Branch
Ron Southworth, Mgr.
Program Support Branch
Kathy Burke (Acting), Mgr.
Research, Evaluation & Training Branch
VACANT, Mgr.
DIVISION OF MENTAL RETARDATION
Betsy Dunnigan (Acting), Director
Claudia Johnson, Assistant Director
Betsy Dunnigan, Assistant Director
SCL Waiver Branch
VACANT, Mgr.
Systems Support Branch
Kedra Weinrauch, Mgr.

Recent Challenges and Achievements

Recovery Initiatives (Consumer Involvement)
Since 2003, the Department has supported "Leadership Academy" training for adults with severe mental illnesses. Utilizing trainers from CONTAC in West Virginia, two Leadership Academies and one "Train the Trainers" session has been offered. Graduates are now conducting leadership trainings in their own communities. To date, 229 consumers have attended the events. Topics such as etiquette of consumer involvement, identifying issues, gathering information and making presentations, conducting meetings and forming advocacy organizations are all part of the statewide and regional trainings. In addition, the Mental Health Consumer Advisory Committee meets quarterly with an average attendance of 60 people to discuss topics of interest to consumers, family members and professionals. This year committee members elected seven members to serve on a Steering Committee that will identify issues to be presented to the full committee. Legislation authorizing Advance Psychiatric Directives was passed in the 2004 session of the General Assembly and efforts are ongoing to educate consumers, the public at large and providers (hospitals) about the standardized form and the process to be used. A consumer-directed organization, Kentucky Consumer Advocacy Network (KY CAN), is coordinating recovery-oriented peer reviews of regional Community Support Programs. Please see web site for additional information about Consumer services at: http://mhmr.ky.gov/mhsas/Consumer.asp

Best Practices
The 2005 General Assembly passed Senate Joint Resolution 94 (SJR 94). This legislation requires expansion of consumer self-directed, community-based services that support independence and productivity using best practices. It also directs the Department to develop incentives and provide training related to the adoption of best practices by Regional Boards and to continue negotiations with Medicaid staff regarding reimbursement for such services.

Evidence-Based Practices has been the theme of the Department sponsored "Mental Health Institute", an annual three day training event that provides continuing education to over 800 clinicians and other stakeholders. This year a small portion of block grant funds will support a pre-institute with the choice of two full-day sessions, one entitled "Best Practice Implementation" with Michael Hogan as the keynote while Ginny Thornburgh, Director of the National Organization on Disability's Religion and Disability Program, will be the keynote speaker for the other session about Faith-Based Initiatives.

Kentuckians Encouraging Youth to Succeed (KEYS), Kentucky's recently funded CMHS Children's Mental Health Initiative (systems of care cooperative agreement), will facilitate the implementation of a continuum of positive behavior interventions and supports in targeted schools in the North Central region of Kentucky. Recognizing the unmet needs of youth with co-occurring mental health and substance use disorders, KEYS will place particular emphasis upon employing evidence-based strategies to effectively identify and treat this challenging population.

Emergency Services
In recent years, initiatives with varied funding sources have provided for completion of the crisis stabilization network, a statewide jail triage system, statewide disaster preparedness and creation of a statewide suicide prevention plan. Department staff is currently focusing on creating guidelines, performance indicators and options for

blended funding to further enhance and sustain a full array of coordinated emergency services. The Department was recently awarded a NASMHPD/NTAC Technical Assistant grant to conduct a statewide forum with Cabinet and Department officials to meet with local law enforcement, private and public service providers and others. Utilizing a "systems mapping" process, their goal will be to create a template to address the gaps in the current emergency services network across the state.

Increasing Admissions to State Hospitals

The trend for closure of psychiatric units in community hospitals is affecting admissions in state hospitals. While no definitive trend has emerged, there is a risk that access to appropriate lengths of care will become more difficult, re-hospitalization rates will increase, and outcomes of treatment will deteriorate. The Department has continued to work with the Bristol Observatory to compare state hospital, private psychiatric unit, and community mental health utilization by adults with severe mental illnesses, and is monitoring trends through "Continuity of Care" meetings between state hospitals and their corresponding Regional Boards.

Adolescent Substance Abuse

In August 2005, Kentucky was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) grant which will provide $1.2 million over three years to enhance the infrastructure supports for adolescent substance abuse treatment. In addition to increasing access to treatment services for young people, it will allow for the creation of a staff position dedicated to ensuring resources available for substance abuse treatment are being used in the most efficient manner possible.

System Change Activities

State Government Reorganization

With a new Governor in January 2004, state government in Kentucky has undergone a major reorganization. The Cabinet for Health Services (the original umbrella Cabinet for KDMHMRS) has been merged with the Cabinet for Children and Families into the Cabinet for Health and Family Services. At the Department level, the Divisions of Mental Health and Substance Abuse have been merged into one Division with four new branches. The new Division of Mental Health and Substance Abuse (DMHSA) is now comprised of four Branches including: Program Development; Brain Injury; Program Support; and Provider Services. There is staff from the former branches of mental health adult services, mental health children's services, substance abuse services, and adolescent substance abuse services in each of the new branches to ensure knowledge base of the targeted populations served.

Faith-Based Initiative

The Department has sponsored three organizational meetings, with an open invitation to all interested parties, to begin to outline the vision and mission of a statewide faith-based initiative. Response from interested parties across the state continues to grow with approximately fifty faith-based organizations who have expressed an interest in being involved in the initiative in some fashion. A department wide workgroup developed a goal statement for the statewide initiative that included working with faith-based coalitions to ensure that grassroots leaders can compete on an equal footing for federal dollars, receive greater private support, and face fewer bureaucratic barriers. The Department can assist any interested faith-based organization in locating resources,

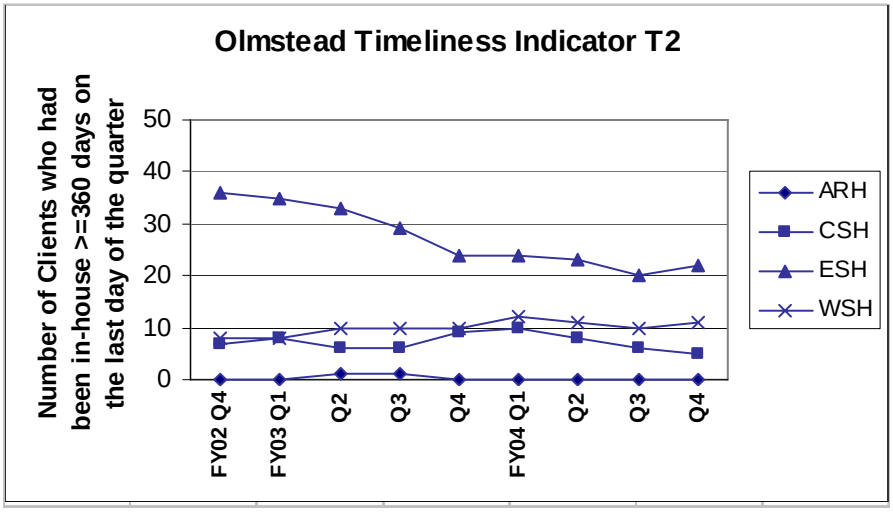
assessing gaps in needed services, identifying funding opportunities, providing training and technical assistance in grant writing, and sharing information on evidence- based practices.

Olmstead Planning

Olmstead planning activities in Kentucky began with grant funding from the Robert Wood Johnson Foundation and the Center for Health Care Strategies that convened a broad stakeholder group in 2000. The Olmstead Planning Committee presented a final report to the Cabinet for Health Services in October 2001. In response, the Cabinet issued an Olmstead Compliance Plan and in 2002 established the "Olmstead State Consumer Advisory Council" to advise the Cabinet on implementation of the plan.

A CMHS grant, supplemented by state funds, supports the participation of mental health consumers and advocates in education and outreach activities related to the Olmstead decision. The project deploys peer advocates to assist individuals with severe mental illness who are transitioning from institutions to the community. Grant-funded peer advocacy proved to be a critical factor in the successful transition of several very challenging individuals to the community.

In 2003, the Cabinet for Health and Family Services entered into a Voluntary Compliance Agreement with the federal Office of Civil Rights that outlines actions that KDMHMRS will take to insure that individuals residing in state psychiatric hospitals are assisted in developing transition plans to move to the community as quickly as possible. A performance monitoring system, new policies and procedures, and new community resources ("Olmstead Wraparound Funds") were created. As a result, a significant reduction in the number of individuals hospitalized over one year has been achieved (see chart below).



Kentucky's Legislature has provided $800,000 in Olmstead "Wraparound" funding to assist in discharge planning efforts for individuals with complex service needs. The Department has established four Olmstead Transition Committees at each of the four state hospitals that meet and plan for community placement. These Transition Committees are comprised of hospital discharge staff, community service providers, state staff and family and consumer organization members. They have successfully

placed a number of individuals in the community who would not otherwise have had the opportunity to leave the hospital setting. Even though funding is not adequate to meet all needs, these Committees have been identifying barriers to community placement that will be used as the basis for future budget requests.

HB 843 Commission

The Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol, and Other Drug Disorders (called the HB 843 Commission), created by legislation in 2000, continues to serve as a catalyst for transforming the behavioral health system in Kentucky. There is a regional planning process that analyzes needs and assigns priority for service development in the fourteen mental health regions. Oversight of the process is vested in the HB 843 Commission, which is co-chaired by the Secretary of the Cabinet for Health and Family Services and a member of the General Assembly. The HB 843 Commission includes state agencies with a stake in mental health and substance abuse services, legislators, and consumers and family members. The Commission meets at least quarterly and reports annually to the General Assembly. The primary accomplishment of the Commission has been building the consensus necessary in the Executive and Legislative branches for expansions of mental health and substance abuse budgets. A secondary accomplishment has been a more inclusive and progressive dialogue about desired changes to mental health law, for example, Advance Psychiatric Directives. The regional planning councils often review plans submitted by Regional Boards for CMHS Block Grant funds, building on the regional planning authority vested in the Regional Boards by statute.

Legislative Initiatives

During the 2005 legislative session, passage of a budget was the first priority. The budget bill (HB 267) appropriates funds for the ongoing operation of state government for the remainder of the biennium. Contained within this bill is provision for flat line funding to DMHMRS except for the following:

- An additional $1.9 million through SFY 2006 to support an additional 25 individuals served through the Acquired Brain Injury Services Program (contained in the Medicaid Benefits portion of the budget bill);
- An additional $2 million in SFY 2006, provided as flexible, “safety net” funds to serve those with no payer source. These funds will be allocated to the Regional Boards and may be spread across mental health, mental retardation and substance abuse programs;
- One hundred thousand dollars to establish a Homeless Prevention Pilot Project in one urban and one rural county; and
- A total of $150,000 to support Phase II of the Elizabethtown/Washington County Duplex Project.

House Bill 296 establishes the Kentucky Commission on Autism Spectrum Disorders and directs it to develop a comprehensive state plan, along with a timeline for implementation, to better serve individuals with Autism Spectrum Disorder.

State Service Delivery System

KDMHMRS is identified by Kentucky Revised Statute (KRS) 194.030 as the primary state agency for developing and administering programs for the prevention, detection and treatment of mental health, mental retardation and substance abuse disorders.

To fulfill its statutory mandate to develop and administer a comprehensive mental health services system, KDMHMRS provides:

- Inpatient psychiatric evaluation and treatment at four state hospitals (two operated directly, and two through contracts);
- Inpatient forensic evaluation and treatment at a prison facility licensed as a hospital;
- Nursing care at two facilities;
- Personal care at three facilities (through contracts); and
- Outpatient services primarily through a network of Regional Boards, also called "community mental health centers."

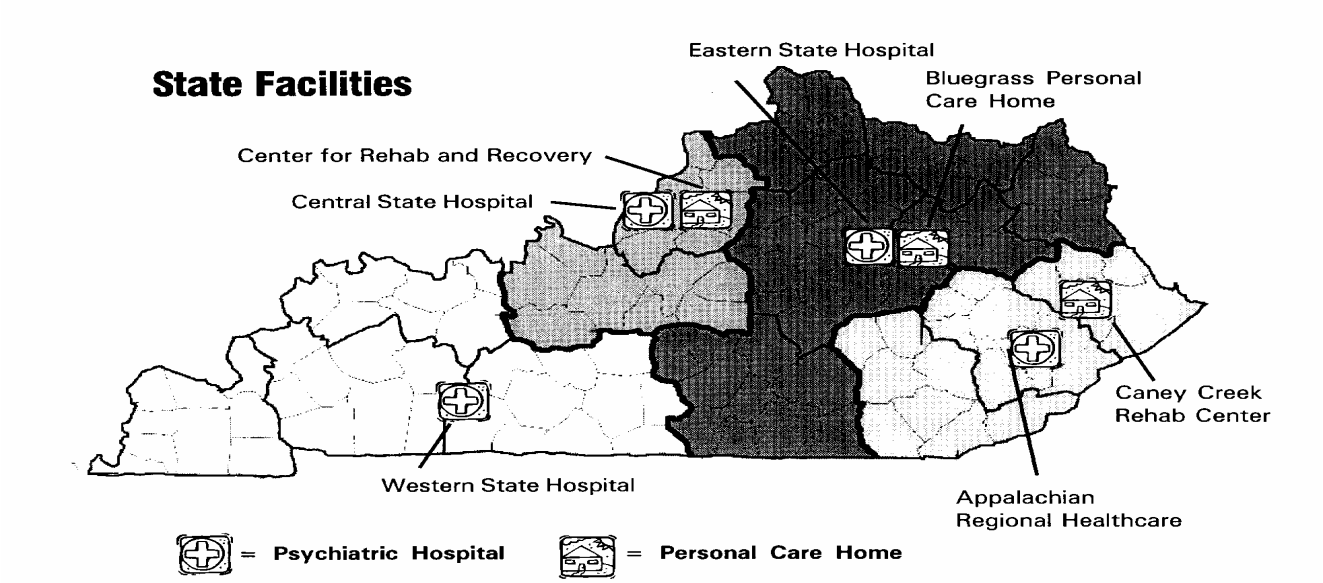
Inpatient Facilities

For over 160 years, Kentucky has operated psychiatric facilities that provide evaluation and treatment. Kentucky's state hospitals for adults are:

State Hospital	Location	Operation	Census*
Western State Hospital	Hopkinsville	State operated	144
Central State Hospital	Louisville	State operated	108
Eastern State Hospital	Lexington	Contracted	162
ARH Hazard Psychiatric Center	Hazard	Contracted	82

* SFY 2005 Average Daily Census

Census at state hospitals had declined over the past decade as efforts were made to place persons in appropriate community programs. However, due to the closing of many psychiatric units within local (med/surg) hospitals, it is anticipated that the number of individuals served by the state facilities may rise. Trend data is available in Section III within the plan for adults with SMI.



To facilitate the coordination of community mental health programs and state hospitals, each hospital has a catchment district that includes the regions of nearby Regional Boards (see map above). Other ways that the Department facilitates coordination of care among its facilities and community programs are discussed in a later part of this section.

Kentucky does not operate a state hospital for children. Psychiatric hospitalization for children is widely available through approximately 612 psychiatric beds. These hospitals reported an occupancy rate of 46.6 percent in calendar year 2004 (up from 44.6 the previous year).

Nursing Homes

The Department operates two facilities that provide a nursing level of care for persons with psychiatric disabilities who also need a nursing level of care for a co-morbid condition, or because they are medically fragile. The facilities primarily serve persons who are discharged from state hospitals, or who are at risk of hospitalization in a state facility. They are:

- WSH Nursing Facility, located on the campus of Western State Hospital in Hopkinsville and caring for approximately 134 persons; and
- Glasgow Nursing Facility, in Glasgow and caring for approximately 86 persons.

Personal Care Homes

To provide a less restrictive alternative for people in state hospitals who choose a transitional placement from a hospital level of care, specialized personal care homes for adults with SMI are available in three of the four hospital districts (admissions are not restricted to residents of regions or districts). These homes are operated by Regional Boards.

The focus of the rehabilitative programming within these facilities is the teaching of skills and behaviors that will enable residents to be integrated into the community. They are:

- Center for Rehabilitation and Recovery, located on the campus of Central State Hospital outside Louisville, and housing 38 persons;
- Bluegrass Personal Care Home, located on the campus of Eastern State Hospital in Lexington, and housing 35 persons; and
- Caney Creek Personal Rehabilitation Complex, located in Pippa Passes in southeastern Kentucky, and housing 73 persons.

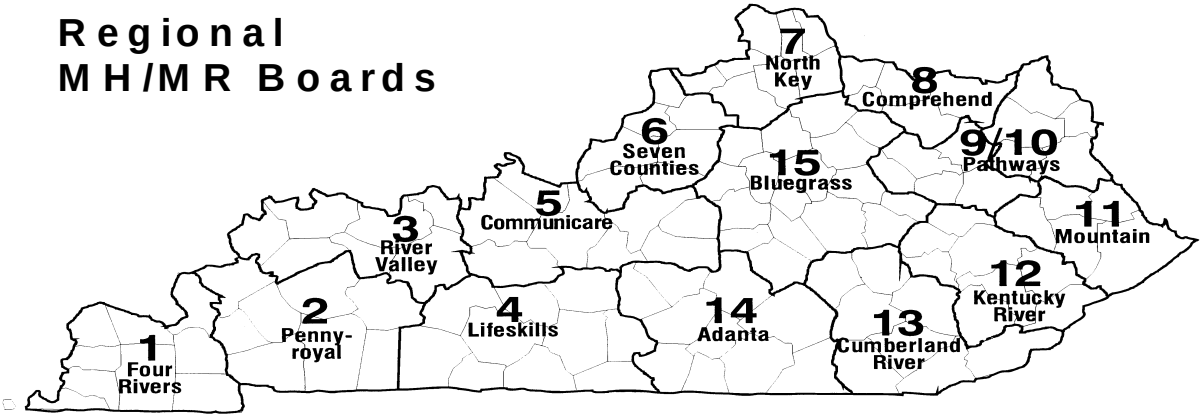
Forensic Psychiatric Services

Kentucky Correctional Psychiatric Center is a maximum-security inpatient psychiatric hospital operated by the Department. It primarily provides inpatient evaluation and treatment to restore competency, if ordered, to persons charged with a felony offense. When inpatient evaluation is unnecessary, the center facilitates outpatient competency evaluations through contracts for professional services with Regional Boards. The facility's average daily census in SFY 2005 was 65 persons.

Regional Programs

Kentucky is divided into fourteen geographic regions for the purposes of planning and providing publicly funded community mental health services. Together, they serve all 120 Kentucky counties. For each region, a Regional Board has been established pursuant to KRS 210.370-210.480 as the planning authority for community mental health programs in the region. A Regional Board is:

- An independent non-profit organization;
- Overseen by a volunteer board of directors that broadly represents stakeholders and counties in the region; and
- Licensed by the Cabinet for Health and Family Services as a "community mental health center."



Statutes require that a Regional Board provide, at a minimum, the following mental health services:

- Inpatient (typically by referral agreement);
- Outpatient;
- Partial hospitalization/psychosocial rehabilitation;
- Emergency; and
- Consultation and education.

Regional Boards have collaborated with KDMHMRS to expand the array of community mental health services beyond those services mandated by law. KDMHMRS and the

Regional Boards have historically used the CMHS Block Grant to drive the creation of an array of preventive, supportive, and rehabilitative services that are oriented to recovery so that adults with SMI and children with SED can live, work, and enjoy meaningful relationships with other members of their communities.

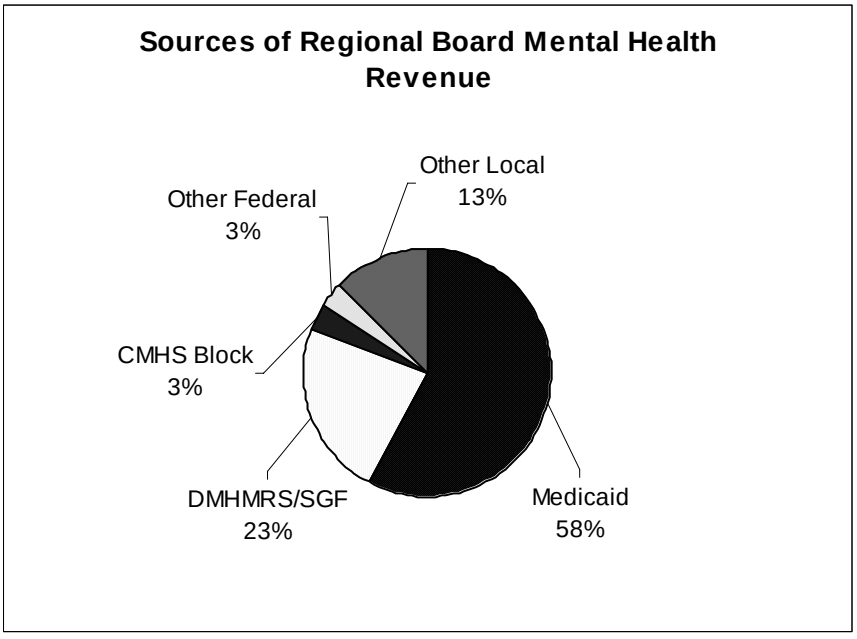
County and municipal governments do not provide community mental health services. However, some local health departments are using HRSA grants to provide mental health services to patients with co-morbid conditions, primarily case management.

Community Mental Health Funding

Mental health services by Regional Boards rely on several funding streams including:

- *State General Funds* which are appropriated to KDMHMRS by the General Assembly for "Community Care and Support" and for flexible and restricted mental health purposes and allocated to the Regional Boards.
- *Medicaid* dollars which are earned through billings to the state Medicaid program by staff qualified to serve Medicaid eligible consumers. Medicare is also a source of federal revenues through qualified billings although those dollars are not included in the chart below;
- *Mental Health Block Grant* (federal funds) which are received by KDMHMRS and allocated to the Regional Boards;
- *Other Federal Funds* are specific grants awarded to the state for a specific purpose (e.g., PATH, KEYS, BRIDGES, Olmstead, etc.); and
- *Other Local Funds* from mental health taxes (in a few counties), charitable organizations/foundations or other state and federal funds that are allocated through other Departments or directly to the corresponding Regional MH/MR Board. Some Regional Boards also receive revenues from counties through special taxing districts.

The following table and chart displays the size and relative contribution of major funding sources to the total during SFY 2005.



Source of Revenue	*Revenue*	*Percent*
Medicaid	$99,695,953	55.3%
DMHMRS/SGF	$48,769,192	27.0%
CMHS Block (includes carryover)	$5,650,184	3.1%
Other Federal (includes Impact Plus)	$4,209,066	2.3%
Other Local	$22,006,233	12.2%
Total	$180,330,628	100.0%

State General Funds

The General Assembly appropriates two types of state funds that are used for community mental health services including:

- Community Care and Support which are funds allocated for all three KDMHMRS program areas (substance abuse, mental retardation, and mental health). These funds are allocated by KDMHMRS to the Regional Boards using a formula primarily based on population size. They decide how to use these funds within programs to cover shortfalls from other revenue sources when they serve people who lack Medicaid, Medicare, or private insurance; and
- Flexible and Restricted Mental Health funds that are appropriated specifically for mental health services. Some of these funds may be historically tied to a specific service. Others may be limited to a specific population such as adults with SMI or children with SED. A small portion is flexible and is budgeted by the Regional Board as needed.

Most community mental health funds appropriated to KDMHMRS are contracted to the Regional Boards, except for state-level initiatives such as housing programs. Regional Boards may subcontract some services to other local agencies through affiliate agreements.

Nationally, Kentucky ranks 41st in per capita expenditures for mental health services. Concerns over Kentucky's standing among its peers in the nation helped prompt the creation of the HB 843 Commission, which was discussed in an earlier part of this section.

Medicaid

Kentucky's Medicaid State Plan includes the optional "Rehabilitation" element, which covers "Community Mental Health Services." Only Regional Boards licensed as Community Mental Health Centers may enroll as providers. The covered services include:

- Outpatient services by psychiatrists, physicians, and other mental health professionals (licensed or under supervision);
- Collateral services by professional staff to parents and other caregivers for children;
- In-Home services by professional staff; and
- Therapeutic Rehabilitation services.

Medicaid also covers Targeted Case Management Services by Regional Boards to adults with SMI and children with SED. Additionally, Medicaid covers IMPACT Plus

services, an individualized and flexible program of services for children at risk of institutionalization. Provider participation is not limited to Regional Boards and the network includes many new or non-traditional mental health organizations. IMPACT Plus is more fully described in Section III under the Plan for Children with SED.

KDMHMRS works closely with Kentucky Medicaid to coordinate state and Medicaid coverage requirements so that program planning is consistent and service provision to people who gain or lose Medicaid eligibility may be seamless.

Like most other states, Kentucky is facing a crisis in state revenues for its Medicaid match. So far, Medicaid's coverage of mental health services has been maintained using an array of strategies that have not caused wholesale interruptions in services. However, with such a serious state Medicaid deficit and tightening of federal Medicaid guidelines and benefits, changes are inevitable in the near future.

Mental Health Block Grant
Mental Health Block Grant funds are drawn down by Kentucky through the submission and acceptance of this planning document to CMHS. These funds are often used for programs that are not reimbursable through Medicaid, especially programs that advance systems of care. The funds are limited to programs for adults with SMI and children with SED.

Prior to a change in methodology that began in SFY 2001, block grant funds had been awarded to Regional Boards based on a competitive "request for proposal" process. Currently, new funds are awarded to bring regions to per capita equity. Regional Boards submit plans to strengthen their systems of care, the plans are reviewed by regional stakeholder councils, and, if approved, the Regional Boards may flexibly allocate the funds in accordance with the plan.

Plans are submitted as part of the Regional Boards' annual "Plan and Budget" application process. Information from regional plans for SFY 2006 has been incorporated in the planning documents for adults with severe mental illness and children with severe emotional disturbances, included in Section III.

Coordination of Mental Health Care

KDMHMRS coordinates inpatient and outpatient services in various ways.

1. Regulations, administrative direction, and contract provisions have numerous requirements related to continuity care. For example:
   - Persons who are brought before the court for evaluation for involuntary psychiatric commitment are required to receive the evaluation from a Qualified Mental Health Professional in the community;
   - Regional Boards are required to provide a case management assessment when a hospital discharges a person with a SMI who needs it;

2. Performance data on key indicators of continuity of care are also collected. Measures include:
   - Readmissions;
   - Outpatient visits within 7, 14 and 30 days of discharge; and

- Case management contacts following a case management referral.

3. "Continuity of Care Committees" have been organized for each of the hospital districts to include representatives of the hospital and the Regional Boards who refer clients to the hospital. The committees review Continuity of Care performance indicators and discuss strategies for performance improvement.

4. Staff of the Regional MH/MR Boards participate on the Governing or Advisory Boards of the four state hospitals.

5. Department leadership and their designated staff participate on a wide range of interagency boards and commissions that have mental health within their scope of work.

Mental Health Services Planning Council

The Kentucky Mental Health Services Planning Council meets at least four times a year. At its August meeting, it reviews and comments on the state's Plan. At its November meeting, it reviews and comments on the state's Implementation Report. However, most meetings are spent discussing mental health issues or learning more about Kentucky's implementation of national initiatives related to the Block Grant. For example, this year the Council has had several presentations including:

- The President's New Freedom Commission on Mental Health Report;
- Evidence-Based and Promising Practices; and
- Legislative Initiatives.

Last fall, the Kentucky Planning Council was among the first in our region to "cross-walk" the state's Block Grant Plan with the New Freedom Commission Report, identifying strengths and weaknesses of Kentucky's plan.

Officers of the Planning Council are consumers, family members, or parents of a child with a SED. In addition, the Council includes a representative of young adults in transition. The Council also has broad representation and involvement from other state agencies.

It is anticipated that there will be considerable turn over in the membership of the Council in the next few months and the need for a thorough member orientation session, facilitated by the National Association of Mental Health Planning and Advisory Councils members is scheduled for March 15, 2006.

Section II: Identification and Analysis of the Service System's Strengths, Needs and Priorities

This section of the narrative provides a planning context for the plans for adults and children in Section III. Narratives are provided that discuss:

- Strengths and Weaknesses of the Service System
- Unmet Service Needs and Critical Gaps
- Priorities and Plans to Meet Unmet Needs
- Recent Significant Achievements
- Vision for Kentucky's Systems of Care

Strengths and Weaknesses of the Service System

Kentucky has continually strived to provide community-based services for adult with SMI and children with SED, allowing individuals to remain in their own homes and communities whenever possible. Some communities are better equipped to make this a reality than others.

Historically, Kentucky spends less than most states on its system of care for persons with mental illness and substance abuse disorders, and ranks 41st in per capita expenditures for mental health services; at the same time, it has a reputation for innovation and quality. The majority of the Regional Boards have seen a steady increase in adult and child consumers served over the past five years.

The network of private, not-for-profits Regional Boards in Kentucky is strong and has been generally stable for decades. However, because each is a private business entity standardization of admission criteria, services array, management and information systems, client records is limited only to the provisions required through contract or licensure. Most Kentucky communities attempt to coordinate their public and private mental health and substance abuse services. However, demand that exceeds needs and the complexity of funding makes coordination very difficult. Although the 2000 General Assembly passed legislation requiring parity, or equality, of mental health and substance abuse services with physical health services, its application was limited to large group employers who are not self-insured.

In recent years, planning efforts have become increasingly comprehensive and coordinated and collection of data has improved, yet there are often intervening issues that must be added and may require immediate attention. The high incidence of methamphetamine production and abuse, and its devastating effects on all service systems (treatment services, child welfare, law enforcement and local communities), is one such occurrence. Kentucky is struggling, like many states, to continue serving its most venerable citizens with ever lessening resources.

Unmet Service Needs and Critical Gaps

The HB 843 Commission process required the state's 14 Regional Boards to convene "Regional Planning Councils" of stakeholders to assess needs, identify gaps, and recommend changes in policy and funding for mental health and substance abuse disorders, including services to people with co-occurring disorders. The Councils' reports were submitted to the state Commission, which includes representatives of executive

branch departments and six legislators, who compiled a state plan. The process builds on the regional planning authority vested in the Regional Boards by statute.

A number of themes were identified by many, if not all, of the Regional Planning councils during the course of their work. These were identified by the Commission as "Common Issues" and are these:

- Collaboration - ongoing, coordinated communication and action should occur at every level;
- Planning - planning should occur at the regional level to address regional needs and plan for a seamless system of care;
- Fiscal Policy - investment in community mental health and substance abuse services is needed to reduce later, more costly, expenditures and to improve Kentucky's national rank in per capita non-Medicaid spending for mental health and substance abuse services;
- Public Policy - accurate data, outcomes information, and a systems approach are needed to shape policy;
- Public Education - the stigma associated with mental illness and substance abuse should be reduced to encourage earlier identification and intervention;
- Professional Staffing - more professionals are needed in all parts of the state, and they should be cross-trained to address dual diagnosis problems; and
- Transportation - barriers that impede access to effective community services should be reduced.

Department staff have facilitated discussion about Kentucky's status in regard to the report of the President's *New Freedom Commission on Mental Health* with the HB 843 Commission and the Mental Health Services Planning Council. The following challenges for Kentucky were identified, related to the report's goals and recommendations.

Goal *New Freedom Commission*	**Challenges in Kentucky**
1. Americans understand that mental health is essential to overall health	• Reduce suicide rates • Increase efforts to inquire about and incorporate physical/dental health information • Encourage partnerships between local public health departments and Regional Boards
2. Mental health care is consumer and family driven	• Focus on recovery and resiliency • Develop person-centered planning for adults with SMI and children with SED • Strengthen peer advocacy and support
3. Disparities in mental health services are eliminated	• Improve access for Hispanic and other immigrant groups • Recruit professionals to rural areas
4. Early mental health screening, assessment and referral to services are common practice	• Develop evidence-based practices for early childhood and school-based MH services • Partner with primary care to improve

	screening for all, and access for elderly
5. Excellent mental health care is delivered and research is accelerated	• Partner with colleges and universities • Aggressively pursue grants for EBPs and systems change
6. Technology is used to access mental health care and information	• Develop MIS capabilities of Regional Boards • Expand recommendations network • Move toward use of electronic medical records

The Department also continually reviews the performance and outcomes of facility and community-based services it supports for adults with severe mental illness and children with severe emotional disabilities. It reviews performance and outcomes with providers and stakeholder groups that focus on these two priority populations for the Mental Health Block Grant, including:

- The HB 843 Commission;
- The Mental Health Services Planning Council; and
- The State Interagency Council for Children with SED.

The following issues and opportunities have been identified for the two Block Grant service populations:

- Kentucky has a number of significant statewide or regional consumer-oriented initiatives that would benefit from coordination to promote peer advocacy and other strategies that support recovery of adults with severe mental illnesses;
- Rehabilitation practice for adults with severe mental illnesses is currently fragmented and would benefit from technical assistance on best practice models;
- The desired outcomes for IMPACT and Impact Plus, two service systems for children with severe emotional disabilities, need to be revisited;
- Regional Boards and jails should collaborate to improve mental health services for adults with SMI who are in jails, and to direct them to effective community-based programs whenever possible; and
- Opportunities to facilitate the delivery of best practices by providers should be pursued.

Priorities and Plans to Address Unmet Needs

In collaboration with the stakeholder groups and other agency partners, the Department is focusing efforts on the following:

- Coordination and development of consumer advocacy efforts, particularly activities that promote recovery;
- A comprehensive initiative will embed Psychiatric Rehabilitation best practices in Community Support Programs for adults with severe mental illnesses through the use of technical assistance, consumer initiatives, and associated outcomes measures;
- Mental health services will be extended for adults with SMI in jails through local agreements and a new funding stream
- Complete revision of the IMPACT Outcomes system including identification of the outcomes measures and the data collection and analysis methods;

- Continued efforts to decrease psychiatric hospitalization rates for adults and children by thorough analysis of the available data and partnering among public and private providers; and
- Opportunities for sharing knowledge and implementing best practices will be systematically identified and pursued.

Recent Significant Achievements

As a result of planning and advocacy by the Department, the Regional Boards, the HB 843 Commission, and consumers and other stakeholders:

- The network of Crisis Stabilization Programs, begun in 1994, is completed. Each region now has a Crisis Stabilization program for both adults and children;
- Activities that have reduced the number of persons with disabilities who are in state institutions has benefited from "Olmstead Wraparound" funding;
- Laws permitting "Advance Mental Health Directives" and removing barriers to use of community hospitals for involuntary commitments have passed;
- Outcome measures are now administered in all major programs serving adults with severe mental illnesses and children with severe emotional disabilities;
- The accuracy, timeliness, and completeness of provider data essential for performance monitoring is now strengthen by the use of funding incentives; and
- The state has recently been awarded several grants that will assist the promotion of best practices in several areas.

Vision for Kentucky's Systems of Care

Kentucky's vision for its community-based systems of care for adults with SMI and children with SED has historically been developed with broad stakeholder involvement. For adults with SMI, Kentucky's vision has been that consumers be empowered to choose among a full array of coordinated community-based services and supports that include:

- Crisis Stabilization
- Housing Options
- Case Management/ Outreach
- Mental Health Treatment
- Rehabilitation including Vocational
- Consumer and Family Support

For children with SED, the vision has been to build partnerships with parents and other child-serving agencies to create community-based alternatives to hospitalization where available, and to provide a full array of services and supports in communities. Alternatives to hospitalization include:

- Intensive In-Home
- Crisis Stabilization
- Day Treatment
- Treatment Foster Care

And community-based services and supports include:

- Youth and Family Support Networks
- Early Childhood Mental Health Consultation and Treatment Services

- School-Based Consultation and Treatment Services
- Specialized Summer Programs
- Intensive After-School Programs
- Respite Care
- Targeted Case Management Services
- Wraparound
- Community Medication Support Program

Progress toward implementing systems of care that include these elements is further described in Section III in the Adult and Child plans. Since the original vision was outlined, significant developments have occurred that will focus that vision:

- A consensus among providers and consumers that recovery should be the orientation of the system of care for adults with SMI;
- A growing realization that prevention and resiliency should be the organizing theme for the system of care for children with SED;
- The creation by Kentucky's General Assembly of the HB 843 Commission, which is creating new regionally-based partnerships for mental health and substance abuse services;
- The release of the President's New Freedom Commission Report and its influence on stakeholders;
- Initiatives to reduce seclusion and restraint and understand the effects of trauma;
- Growing resources for evaluation and implementation of promising and evidence-based practices;
- Reduced utilization of inpatient services;
- Cost pressures on financial assistance programs for new generation anti-psychotic drugs; and
- Static or reduced public funding for human service systems.

The Department will continue to work with stakeholders through the Mental Health Services Planning Council, the HB 843 Commission, and the State Interagency Council and others to refine the vision. In the meantime, developments that focus our vision are being addressed using the strategies discussed in the Action Plans in the Adult and Child plans.

Section III: Performance Goals and Action Plans

INTRODUCTION

The two plans submitted in this section, for adults with a severe mental illness and children with a severe emotional disability; reflect the evolution of the Department's CMHS Block Grant planning process and the influence of new federal planning requirements.

Kentucky's Regional Planning Process

Historically, CMHS Block Grant funds were awarded for specific projects proposed by Regional MH/MR Boards. The Mental Health Services Planning Council helped the Department to select these focus areas. A number of important pilot initiatives demonstrated the effectiveness of new approaches such as "Community Support," "Peer Advocacy," and "Supported Housing." However, the process resulted in inequitable allocation of funds across Kentucky's population and made further system development contingent on the availability of new federal funds.

With the involvement of the Mental Health Services Planning Council and the Kentucky Association of Regional MH/MR Programs (KARP), the Department began changing how CMHS Block Grant funds were allocated. The change recognized:

- The regional planning authority of Regional MH/MR Boards under Kentucky law;
- The usefulness of CMHS Block Grant funds for leveraging other funding streams;
- The increasing availability of reliable demographic, utilization, and outcomes data; and
- The opportunity to use the CMHS Block Grant planning process to drive regional systems change.

Essentially, the process permits Regional Boards to more flexibly use CMHS Block Grant funds to underwrite the costs of implementing a regionally-approved annual plan. Certain requirements apply to the process of developing a regional plan including:

- The plan must address state-required "Components" related to the federally-mandated "Criteria;"
- The plan must address performance indicators that fall below one standard deviation of the mean of Regional Boards; and
- The plan must document the comments on the plan by a regional planning council of which at least 50 percent are consumers, family members of consumers, or parents of children with SED.

The regional state-level planning process is incremental. At first, the emphasis was on the development of a regional planning document. More recently, priority has been given to regional stakeholder review. Next, more emphasis will be placed on the regional review of performance and outcome data. The Department has the assistance of the Mental Health Services Planning Council in determining requirements for regional plans and in their review.

New Federal Planning Requirements

Federal Planning requirements issued in draft form in early 2004 emphasize measurement of specified performance indicators related to the development of effective systems of care. Plans still must describe the systems of care the Department provides for adults with SMI and children with SED. However, the application now requires the

Department to identify certain performance goals related to indicators it can produce from its information system, and to list activities that will help the Department achieve them.

Organization of this year's plans
The two plans, for adults with SMI and children with SED, continue to be formatted according to the federally-required Criterion.

For adults with SMI:
One: Comprehensive Community Based Mental Health Services System
Two: Estimates of Prevalence and Treated Prevalence and Mental Health Systems Data
Four: Targeted Services to Rural and Homeless Populations
Five: Management Systems

For children with SED:
One: Comprehensive Community Based Mental Health Services System
Two: Children's Mental Health System Data Epidemiology
Three: Integrated Children's Services
Four: Targeted Services to Rural and Homeless Populations
Five: Management Systems
Under each of the Criteria, the following narrative material is provided:

- Introduction—a description of the Components required by the state, with the advice of the Mental Health Services Planning Council, for regional plans;
- Components—for each Component:
  - "Regional perspective"—a roll-up of regional plans for the Component, including activities planned by regions to strengthen it; and
  - "State-level perspective"—an evaluation of the statewide status of the Component, and a description of statewide support Kentucky provides at the state level related to the Component;
- Performance Indicators—the indicators chosen by the Department, with the advice of the Mental Health Services Planning Council, for the Criterion. These are formatted in a federally-prescribed table; and
- Action Plans— the performance improvement activities the Department will undertake for the indicators that the Department, with the advice of the Mental Health Services Planning Council, has selected for improvement.

Following each criterion, comments of the Mental Health Services Planning Council at its meeting in August 2005, are provided.

ADULTS WITH SEVERE MENTAL ILLNESS

Criterion 1: Comprehensive Community Based Mental Health System

The plan provides for the establishment of a recovery oriented, comprehensive, community-based system of mental health care for adults who have a severe mental illness, including case management, treatment, rehabilitation, employment, housing, educational, medical, dental, and other support services, which enables individuals to function in the community and reduces the rate of hospitalization.

GOAL: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.

Description of the Organization of the System of Care

The Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) administers a recovery oriented, comprehensive, community-based system of mental health care for adults with severe mental illness through contracts with Kentucky's Regional Mental Health/Mental Retardation Boards. KDMHMRS works with Kentucky Medicaid so that basic services, like outpatient and rehabilitation services, are available and have similar requirements for Medicaid and non-Medicaid eligible consumers.

To encourage the development by Regional Boards of a full array of clinical, rehabilitation, and support services for adults with severe mental illness within their regions, KDMHMRS uses two strategies within its budgeting process. These strategies are:

- Priority Populations
- Community Support Services

Since 1985, KDMHMRS has required Regional Boards to prioritize certain populations, including adults with severe mental illnesses, in their budgeting processes. Despite budget deficits and competing priorities among the various program areas and service initiatives, funding levels for adults with severe mental illness have been maintained. As new funds have become available, further development of an array of community-based services has occurred. In addition, sub-populations who are historically under or inappropriately served have been prioritized including adults with severe mental illnesses who:

- Have co-occurring disorders;
- Are homeless;
- Are deaf or hard of hearing;
- Are elderly;
- Are of African-American descent.

The Ideal Array of Community Support Services

To effectively meet the needs of adults with severe mental illness, KDMHMRS has worked with consumers and other stakeholders to identify and fund an ideal array of services that support adults with severe mental illness in the community. These are organized along six major components:

- **Consumer and Family support**
- **Mental Health Services**
- **Emergency Services**
- **Specialized Services for Adults with Severe and Persistent Mental Illness**

The narrative provided for Criterion One describes these key components of the comprehensive Community Support Services array, and presents State Perspective objectives for the coming year for their continued development. A list of Community Support Services in the ideal array and a representation of their current availability by region are shown in the following table:

Regional Availability of Community Support Services SFY 2006

	Region													
COMMUNITY SUPPORT COMPONENT	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9/ 10**	**11**	**12**	**13**	**14**	**15**
CONSUMER AND FAMILY SUPPORT														
Training and Advocacy		X	X	X	X	X	X			X	X	X		
Consumer Support Group		X	X	X		X	X			X	X	X	X	X
Local NAMI of Kentucky		X	x	X	X	X	X		X			X	X	X
Consumer Conferences	X					X					X	X		X
Peer Advocates/Crisis Response				X		X	X			X				
EMERGENCY SERVICES														
Emergency-Help Line	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Walk-In Crisis Services (8-5,M-F)	X	X	X	X	X		X	X	X	X	X	X	X	X
Mobile Crisis Services		X					X		X		X			X
Residential Crisis Stabilization	X		X	X	X	X		X	X	X	X	X	X	X
MENTAL HEALTH TREATMENT Medication Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Community Medications Support	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Outpatient Therapy	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Intensive Outpatient		X												
Continuity of Care	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Integrated MH and SA Services					X	X					X			X
SPECIALIZED MENTAL HEALTH TREATMENT														
Case Management	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Wrap around Services	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Therapeutic Rehabilitation	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Supported Employment			X	X		X			X	X		X	X	X
Educational Services					X	X		X	X	X	X			X
Other Community Support	X	X	X	X	X	X	X		X	X	X	X	X	X
Specialized Int. Case Management		X		X							X			
Assertive Community Treatment	X										X			
Homeless Outreach	X	X		X		X		X			X			X
Payee Services		X	X		X	X	X	X	X					X
Supported Housing		X	X	X	X	X					X			X
Residential Support		X	X	X	X	X	X		X		X	X		X
Housing Development		X		X		X	X		X					X
Criminal Justice	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Physical Health						X								
Aging														
Deaf/Hard of Hearing	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Brain Injury														

COMPONENT 1: Consumer and Family Support

Regional Perspective
The regional community mental health centers have reported in their annual plan and budget reports that:

- Eleven regions have Training and Advocacy initiatives;
- Ten regions have consumer support groups;
- Five regions have consumer run drop in centers;
- Nine regions have local NAMI chapters;
- Nine regions have a consumer conference and/or support other regional consumer conferences;
- Three regions have consumer peer advocates;
- One region has consumer peer volunteers;
- Seven regions have designated consumer staff;
- One region has Peer Support Teams;
- One region has a Recovery Network to support homeless SMI;
- One region practices ACT with consumers involved on planning teams;
- Thirteen regions have consumer involvement on board of directors/planning committees.

In addition, many Regional Boards reported that supporting consumer involvement in consumer conferences, the Mental Health Consumer Advocacy Committee, the Leadership Academy, and other statewide initiatives by providing transportation has heightened consumer access to knowledge and involvement in planning a consumer and family driven mental health care system.

State Perspective
Since the mid-1980s, KDMHMRS has been committed to consumer and family involvement in program development and service delivery as a strategy for strengthening informal community supports. This focus has empowered consumers and family members to become more active in assisting Department staff in developing policies, monitoring and providing technical assistance to local programs, and evaluating requests for funding.

The Department provides funds for a variety of statewide and local consumer and family support initiatives. Each has goals related to advocacy, research, discrimination, wellness and recovery programs, peer support, education and training, and operating support.

The **Mental Health Consumer Advocacy Steering Committee** is a consumer, family member and professional education and involvement function that the Department has supported for approximately fifteen years. The Committee provides a way for the Department to fulfill its Block Grant obligation to involve consumers in planning. It also provides a direct communication link to consumers, family members and professionals who are interested in the planning process for mental health services through the Department. Finally, it brings together grass roots organizations with similar missions to reduce duplication of effort.

Through its membership, the following services are provided:

- Provides consumer, family, and mental health professional education programs;
- Promotes discussion of upcoming and pending legislation of interest to consumers, families, and mental health professionals;
- Provides an opportunity for participants who are involved in the regional community mental health centers to report on initiatives in their regions and to learn about other regional initiatives;
- Creates an environment for members who have attended the Leadership Academy to improve their leadership skills by participating in the meeting process.

The **Commonground Training and Resource Center (CTC)**, a joint project of the Kentucky Consumer Advocate Network (KY CAN), and NAMI Kentucky, is a consumer run technical assistance

center designed for statewide training, information dissemination, and technical assistance. Activities provided by the CTC include the coordination of the leadership academies, provision of hardware and software support to KYCAN, NAMI and individual consumers and family members, technical assistance in planning, services provision, and internet technology. Activities proposed for SFY 2006 include:

- Continue the use of technology to expand access to the Mental Health Consumer Advocacy Committee;
- Initiate a program that uses multimedia to address issues of discrimination against consumers;
- Advocate for family and consumer technical participation; and
- Explore and use technology to provide cost effective service and consensus building.

KDMHMRS and the Regional Boards use a number of strategies to support consumer and family involvement. While funds are limited, a significant amount of block grant funding supports the operations of the statewide consumer organization, Kentucky Consumer Advocacy Network (KY CAN), and the statewide family organization, NAMI Kentucky.

Additional strategies will include:

- Encouraging increased collaboration between Regional Boards and KY CAN and NAMI Kentucky in sponsoring “Bridges” and “Family-to-Family” support groups;
- Continuing to provide reimbursement for consumer and family members to attend state and regional meetings, conferences, and other gatherings;
- Requiring that regional planning councils review plans submitted to KDMHMRS regarding block grant funds;
- Continue to encourage a consistent grievance process statewide;
- Continue to sponsor the Consumer Leadership Training Academy and Train-the-Trainer Academy. Two, three and a half day trainings are being planned that will be taught by consumer graduates of the first trainings. A facilitator from West Virginia CONTAC will also participate.
- A consumer has been hired to coordinate regional Leadership Trainings by utilizing the skills of 25 consumers who have graduated from Levels 1 and 2 of the training.
- Continuing to support the KY CAN Consultative Peer Review program.

The KDMHMRS and the Regional Boards encourage consumer and family member participation in planning, monitoring, and service delivery. To improve existing weaknesses and build on existing strengths, plans are to:

- Accelerate the involvement of consumers and family members in the Block Grant planning process.
- Encourage dedicated funding for consumer run services;
- Design programs and trainings that incorporate recovery principles;
- Implement Supported Employment Training to encourage hiring of consumers;
- Encourage the growth of consumer run services by dedicated funding;
- Create ways to increase statewide consumer participation and all planning events; and to
- Make Recovery Model training available to regional mental health centers.

While KDMHMRS and the Regional Boards have come a long way in fostering consumer and family member participation in planning, monitoring, and service delivery, many challenges remain. These include:

- No dedicated funding for consumer run services;
- Few programs incorporate recovery principles;
- Perception of risk in hiring consumers;
- Limited number of consumer run services that can serve as “mentor” programs; and
- Persistent transportation barriers to attending meeting and other events.

COMPONENT 2: EMERGENCY SERVICES

Regional Perspective

- All fourteen regions have a 24 hour Crisis and Information line;
- All fourteen regions have qualified mental health professionals on call for emergency evaluations for psychiatric hospitalization 24 hours a day, 7 days a week;
- All regions respond within 3 hours to a request for involuntary hospitalization evaluation;
- Crisis Stabilization Units are available in 14 regions;
- Crisis Stabilization Case Management Services are available to 2 regions;
- Training is provided to law enforcement related to accessing emergency care in every region.

State Perspective

Beginning in 1995, KDMHMRS has made a concerted effort to develop a statewide network of Crisis Stabilization Programs. These programs, which primarily serve individuals with serious mental illness, can be home-based interventions or residential units and are a major factor in Kentucky's reduction of inpatient utilization. In SFY 2004, funding was allocated to complete the statewide network by having a Crisis Stabilization Program in each Regional Board service area.

The KDMHMRS Crisis Stabilization Coordinator supports the ongoing development and enhancement of the network by facilitating periodic meetings of crisis stabilization program director and training events.

KDMHMRS funds a full range of crisis services that include:

- 24 hour emergency hotlines;
- Warm lines;
- Walk-in Crisis Services;
- Mobile Crisis Services;
- Suicide Hotlines;
- Residential Crisis Stabilization Units;
- Overnight Crisis Beds;
- 23 Hour Observation Beds in Hospitals; and
- After Hours Face to Face Crisis Evaluations.

A major initiative was implemented in SFY 2005 with the Passage of HB 157 which mandates the establishment of a statewide behavioral health telephonic triage system to be utilized by local jails. This system is used to screen jail inmates at booking for mental health, suicide risk, mental retardation and acquired brain injury and to make recommendations about housing, classification and treatment needs. This is a unique program as no other state in the nation operates a system of screening and assessment through a partnership between community mental health and local jails.

During SFY 2006 KDMHMRS plans to focus more specifically on the development of standards and the identification of evidenced based practices as they relate to Emergency Services. In addition, KDMHMRS has included a specific performance based contract item related to emergency services programs in the contracts for the regional mental health and mental retardation boards. These steps are in line with the Departments focus on transforming the system of care and strengthening the safety net for persons with mental illnesses.

COMPONENT 3: MENTAL HEALTH TREATMEN T

Continuity of Care/Reduction in Inpatient Psychiatric Care

Regional Perspective
KDMHMRS allocated new CMHS Block grant funds during SFY 2001 to develop two outreach specialist positions to evaluate the effectiveness of Strategies to improve aftercare performance by Regional Boards. The Outreach Specialists focus on efforts to engage persons with severe mental illness who have either "served out" from a correctional facility or been recently discharged from a state psychiatric facility. Additional areas of focus for Regional Boards include:

- Ensuring outreach and seamless services to individuals in transition;
- Ensuring that relevant services are available and accessible;
- Maintaining linkages with discharge planners, family members and others; and
- Monitoring relevant performance indicators (appointment follow-up, hospital readmission).

State Perspective
The Department believes that addressing the issue of continuity of care through a well-planned aftercare process is key to ensuring a successful transition from the hospital to the community.

Providing appropriate aftercare following a state hospital stay is critical to reducing readmission rates. The Department requires a Regional Board to provide an outpatient appointment within two weeks of a discharge. KDMHMRS also requires the provision of case management services to adults with severe mental illness who are discharged from a state psychiatric facility, are determined by hospital staff to be in need of case management service, and agree to receive this service.

The fourteen Regional Boards and the state operated/contracted psychiatric hospitals must work closely together to assure continuity of care. Contracts with all parties address continuity issues such as medications, discharge plans, case management and outpatient referrals. Some Regional Boards function as single portal of entry for some of the hospitals. Due to the uniqueness of the providers and each individual they serve, a need to re-institute regular continuity of care meetings between the respective hospital and local Regional Boards was identified in SFY 2002 and KDMHMRS staff initiated the reconvening of these meetings. The agenda for each meeting includes the following topics:

- Aftercare performance;
- Community Medications Support Program;
- Olmstead planning;
- Continuity of care systems issues;
- Consumer issues;
- KDMHMRS Performance Indicators;
- Other issues requested by participants.

During SFY 2005, KDMHMRS worked with each of the state operated/contracted psychiatric hospitals and their assigned Regional MHMR Boards to develop a Memorandum of Agreement (MOA) between the two entities. In order to assure a seamless system of care, the need to develop these MOAs was identified to strengthen the relationships between the hospitals and the Boards. The MOAs include the contractual responsibilities each entity has to the KDMHMRS, but also defines and clarifies roles and responsibilities the hospital and mental health center have to assure quality continuity of care to patients that they both serve.

During SFY 2005 KDMHMRS has worked with the Kentucky Hospital Association, the Kentucky Association of Regional Programs (KARP) The Kentucky Sheriffs Association, State Operated psychiatric hospitals and Regional MHMR Boards to address the increasing reduction of private sector inpatient beds across the state. Over the last two years, there has been a reduction of over 300 private inpatient beds in the state. The consequences, both intended and unintended, of this fact, are of concern to KDMHRS.

Regional forums will be held during SFY 2006 to try to develop some local solutions to assure quality mental health services remain available to persons with mental illness in their local communities.

KDMHMRS strategies to reduce unnecessary psychiatric inpatient utilization include the development of residential crisis stabilization programs, responsive emergency services, assurance of continuity of care and the continued development of other community support services as effective alternatives for adults with severe mental illness who are in crisis.

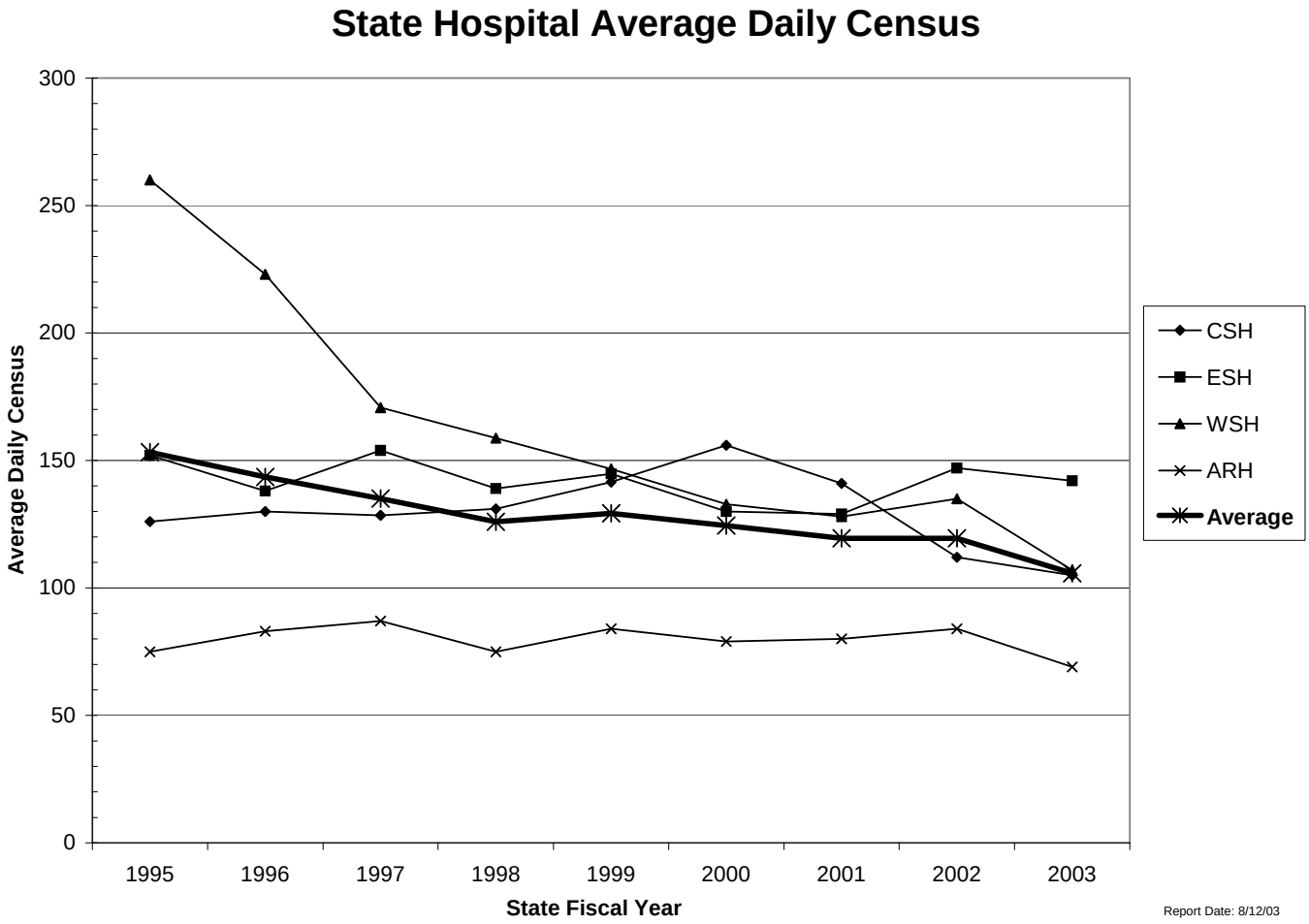
KDMHMRS has responsibility for the monitoring of the **Olmstead Initiative** in each of the four state operated/contracted psychiatric hospital regions. Transition teams comprised of the representatives from the hospital, the Regional MHMR Board, KDMHMRS staff, and other appropriate stakeholders meet on a frequent basis to review transition plans that assure a smooth and timely discharge to the community for identified patients. Funds were appropriated during the 2002 legislative session to pay for individualized and specialized wraparound services to assure the community tenure for each of these individuals.

Kentucky has reduced its state hospital beds by more than 90 percent from the 7,689 beds available in 1955. From SFY 95 through SFY 98 the average daily census decreased by 20% at the four non-forensic state-supported psychiatric hospitals.

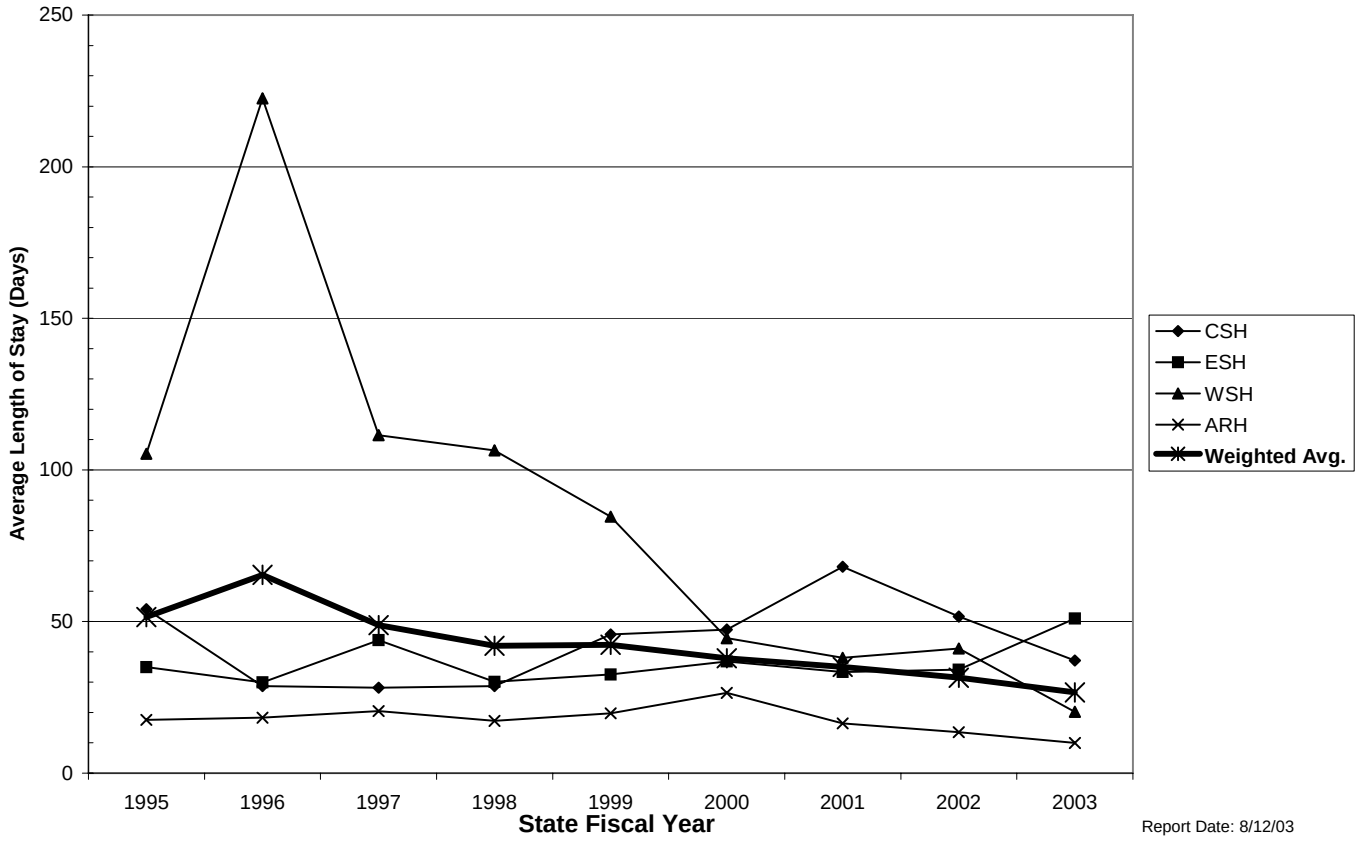
While lengths of stay in state hospitals continue to decrease, continuity of care issues remain. A number of challenges are presented to KDMHMRS and the Regional Boards. These include:

- Private psychiatric beds have been closing or are being converted to acute care beds which generate more revenue;
- The loss of private psychiatric beds in local private hospitals has placed a strain on state operated psychiatric hospital by increasing admissions;
- While crisis stabilization programs have existed in all fourteen regions by the end of SFY 2004, confidence in their appropriateness as alternatives to hospitalization remains low among most psychiatrists; Supervised residential options are sparse throughout Kentucky, thwarting efforts to discharge individuals with complex service needs;
- The unavailability of adequate funding for community-based services as alternatives to hospitalization remains a barrier to good continuity of care; and
- Reduction in funding to the state operated facilities impedes continuity of care.

The following two charts display average daily census and average length of stay within four state hospital settings.


State Hospital Average Daily Census
300
250
200
150
100
50
0
Average Daily Census
1995
1996
1997
1998
1999
2000
2001
2002
2003
State Fiscal Year
CSH
ESH
WSH
ARH
Average
Report Date: 8/12/03

State Hospital Average Length of Stay



Regional Perspective

Traditional mental health treatment in the form of individual therapy, group therapy and psychiatric evaluations are available in every region in the state. Budget constraints have forced some regions to scale back availability of mental health treatment services in less populous, rural counties. Additional areas of focus include:

- While all regions report having a system for following up with missed appointments, most recognize the need to provide assertive outreach so fewer appointments are missed;
- The majority of regions have a method to assure medication continuity within the agency when level of care changes;
- A shortage of professional staff, especially psychiatrists, has caused waiting periods for appointments to continue to grow;
- Continuity of care with inpatient settings and other community providers continues to be a major challenge in providing quality, holistic care;
- Screening for substance abuse disorders/co-occurring disorders occurs in every region with varying levels of comprehensiveness of the assessment process;
- The majority of regions provide opportunities for training regarding substance abuse disorders to their mental health staff.

State Perspective

The Department funds Regional Boards to provide an array of mental health treatment services. These services include medication management, individual therapy, group therapy, intensive outpatient services and integrated services for persons with co-occurring mental health and substance abuse disorders to non-Medicaid individuals with mental illness.

In addition to funding this array of mental health treatment services, KDMHMRS funds the **Community Medication Support Program (CMSP).** The Community Medication Support Program is a drug replacement program that provides low cost medications to the population who are living at a standard below poverty level and who do not otherwise qualify for federal or state assistance. The previous

success of this program is the result of a unique collaborative effort by the state operated/contracted psychiatric hospitals, the Regional Boards, KDMHMRS, and local pharmacies. The goal of the program is to assist adults in the community with a severe mental illness who have no other means of purchasing prescribed psychotropic medication. Prescriptions are filled at local pharmacies, then the medications are replaced to the pharmacies by our state operated/contracted hospitals. The program is available in all regions. Eligibility for the CMSP is based on age (18+), income (federal HHS poverty guidelines and no third party payer sources), and KDMHMRS criteria of severe mental illness (diagnosis, disability and duration).

Current challenges faced include:

- Adequate availability of mental health professionals;
- Assertive Outreach is an identified priority across the Commonwealth;
- Evidence-based practice in clinical care is a KDMHMRS priority and is encouraged and supported at all levels. KDMHMRS is working with individual Boards to introduce the Level of Care Utilization System (LOCUS) and to introduce treatment guidelines for specific mental health conditions;
- HB 843, which established the Kentucky Commission on Services and Supports for Persons with Mental Illness, Alcohol and other Drug Abuse Disorders and Dual Diagnosis, issued their annual report. Included in this report were two significant recommendations related to co-occurring disorders. The Commission emphasized a need for increased initiatives related to cross-systems training for mental health and substance abuse professionals, as well as the development of more integrated service delivery systems, both at the state and local level.

Performance Indicators and Action Plans for this component are at the end of this Criterion

COMPONENT 4: Specialized Mental Health Treatment

Case Management Services

Case management is an essential Community Support Service because it coordinates an individual's service array, making maximum use of available formal and informal supports. Case management has been available through Regional Boards since 1985 and was first covered by Kentucky Medicaid in 1991. Priority is given to adults with severe mental illness who have the greatest difficulties accessing resources and those with more intense service needs. Kentucky embraces a strengths based model advocated by the University of Kansas (Dr. Charles Rapp) blended with the psychiatric rehabilitation model endorsed by Boston University (Dr. William A. Anthony).

Regional Perspective

A review of the information from the SFY 2006 regional plan applications reveals that case management services are available in all 120 of Kentucky's counties. Currently, over 7000 individuals are served by 200 case managers. Case management in Kentucky provides support to individuals in a variety of ways including:

- Three regions have an Assertive Community Treatment Team;
- Three regions have mobile outreach teams;
- Two regions provide specialized intensive case management for forensic clients and;
- Six regions provide continuity of care case management for special populations.

During SFY 2006, efforts will continue to involve stakeholders in identifying key components essential to an Assertive Community Treatment (ACT) model particular to Kentucky, as well as to explore potential funding mechanisms. Additionally, Department staff will continue to provide technical assistance to existing, modified ACT programs operating in the state. Efforts will also continue to develop partnerships and collaborate with state colleges and universities in developing and

incorporating case management training and curriculum into routine class work for students training to provide mental health services.

State Perspective
KDMHMRS supports case management through the Regional Boards in a variety of ways:

- The Division of Mental Health & Substance Abuse, designates a statewide coordinator of case management services;
- KDMHMRS requires and provides certification training for all case managers within six months of employment;
- KDMHMRS, in collaboration with the Kentucky Department of Education Division of Exceptional Children Services, the State Interagency Council for Services to Children with an Emotional Disability, the Kentucky Center for School Safety, the Office of Family Resource and Youth Services Centers, and the Department of Juvenile Justice conducts a continuing education conference that is specific to developing best practices in case management for a broad range of populations and needs;
- KDMHMRS funds demonstration projects for the provision of case management services of a more intensive design to persons with severe mental illness who have a history of violent or volatile behavior;
- Evidence-based practices such as Assertive Community Treatment are in varying stages of implementation as pilot projects in a few regions in the state and are being studied for possible expansion and implementation in other regions; and
- KDMHMRS has established a case management partnership including representatives from mental health, mental retardation, substance abuse, brain injury services, and the Department for Medicaid Services. This partnership, called the case management work group, has developed a common definition, principles and practice guidelines. This group is exploring commonalties for training and service quality improvement.

Rehabilitation Services

Regional Perspective
A review of the information from the SFY 2006 regional plan applications reveals that access to rehabilitation services are available in all 120 of Kentucky's counties.

- All fourteen regions provide access to Therapeutic Rehabilitation Program services with 85 programs available throughout the state;
- Six regions provide access to long term supports through supported employment services for adults with severe mental illness;
- Five regions have specifically adopted the psychiatric rehabilitation model to direct their rehabilitation services; and
- All fourteen regions provide access to educational support through community support program services.

Although adult rehabilitation services are available to individuals in all 120 counties in the state, access to services is inconsistent and often inadequate to meet the need. The federal estimate of 2.6% of the adult population as having a severe and persistent mental illness identifies about 89,000 adults in Kentucky as meeting this criterion.
The majority of adults with severe mental illness in the state do not participate in rehabilitation services offered through the Regional Boards. In SFY 2004, only 4205 adults with severe mental illness participated in a Therapeutic Rehabilitation Program. National estimates report that approximately 43% of adults with a psychiatric disability are employed full or part time yet statistics for Kentucky indicate that only 10% of people with psychiatric disabilities are employed.

The delivery of quality, timely rehabilitation services is challenged by a number of factors including:

- The current billing system that limits therapeutic rehabilitation as a site based service limiting community skills taught in the natural community;
- Kentucky Medicaid rates for therapeutic rehabilitation are quite low and significantly below the reimbursement rate for outpatient treatment services;
- Therapeutic Rehabilitation Program services are inconsistent and have not adopted a specific model of practice with stated values, principles, practice guidelines, and expected outcomes of service;
- Supported employment is not reimbursed by Medicaid and there is limited funding for the long term employment supports needed by adults with a severe mental illness; and
- Supported education is not reimbursed by Medicaid and is actually interpreted by some centers as being discouraged due to the possible interpretation of duplicity of services.

State Perspective

KDMHMRS incorporates the philosophy of "psycho-social rehabilitation" (outcomes improve when skills are taught in a social setting) and **"**recovery**"** (outcomes and satisfaction improve when consumers develop new meaning and purpose in life and grow beyond the catastrophic effects of mental illness) to assist the development of Community Support Services. As psychiatric rehabilitation technology has evolved, KDMHMRS has promoted rehabilitation and recovery models through training, education, technical assistance, and targeted funding opportunities.

KDMHMRS promotes the use of psychiatric rehabilitation technology by regional programs. The Psychiatric Rehabilitation model developed by the Center for Psychiatric Rehabilitation at Boston University was selected as the exemplary model as it has been extensively documented, validated, and replicated in hundreds of different settings for over two decades. This model also addresses the four major components of Community Support Services identified by KDMHMRS with a focus on improving the lives of persons with psychiatric disabilities by enhancing their use of skills and/or environmental supports to live, learn, work, and socialize in the community and role of their choice.

Currently KDMHMRS, Kentucky Medicaid, the Regional Boards, and other providers have not adopted a specific model of practice. Some programs have independently adopted various models but, without system support, have had difficulty implementing and maintaining a commitment to training and outcome measurement. The Psychiatric Rehabilitation model offers a method that would specifically address improvement in skills, functioning, social environment, and role attainment with a proven process, intervention, and technology base.

KDMHMRS supports the provision of three key rehabilitative services at the regional level: therapeutic rehabilitation, supported employment, and supported education. While they each rely on psychiatric rehabilitation technology, they are supported in very different ways.

KDMHMRS supports rehabilitation services through the Regional Boards in a variety of ways:

- The Division of Mental Health and Substance Abuse designates a statewide community support program coordinator;
- KDMHMRS offers technical assistance and training for Community Support Program Directors who coordinate services for the state's eighty-five (85) **therapeutic rehabilitation programs** (TRP). **Therapeutic rehabilitation programs** are goal directed services aimed at improving skills in living, working and socializing in communities of one's choice. Technical assistance is provided to regional programs in how to incorporate psychiatric rehabilitation technology into daily programming;

- KDMHMRS has an interagency agreement with the Department for Vocational Rehabilitation that uses CMHS Block Grant funds to leverage **supported employment** services for adults with severe mental illness. In SFY 2004, 1642 individuals in the state were served with supported employment;
- KDMHMRS worked collaboratively in SFY 2004 and SFY 2005 with the Kentucky Business Leadership Network to increase employment opportunities for adults with severe mental illness through planning and participating in business forums that promote community awareness and education and the implementation of a job placement website for adults with disabilities;
- KDMHMRS worked collaboratively in SFY 2004 and 05 with the Office of Vocational Rehabilitation and the Interdisciplinary Human Development Institute at the University of Kentucky to develop a Supported Employment Training for providers of mental health rehabilitation services in Kentucky which was offered quarterly in various geographic locations throughout the state;
- Improving access to **educational services** through sites that provide Community Support Services was a new priority for SFY 2005. According to the Kentucky Adult Literacy Survey, over 340,000 people lack the literacy skills necessary to compete in the workforce. Lack of literacy skills act as a hindrance to the personal advancement of another 656,000 Kentuckians. The lack of available educational services can seriously hinder persons with a serious mental illness in accessing and maintaining employment, and can negatively impact their quality of life. Providing access to educational support services has been a priority for Community Support Program Directors in community mental health settings.

Housing Options

Regional Perspective

During SFY 2006, KDMHMRS, Kentucky Housing Corporation (KHC) and the Kentucky Association of Regional Programs will continue collaborating on the development of a Statewide Housing Project involving low-income housing tax credits. This project involves the construction of twelve new units of scattered site affordable rental housing in a number of rural counties. Regional Boards will serve as local project sponsors and be responsible for site selection, construction, tenant selection, property management and service provision.

Regional Boards use a variety of strategies to develop housing options for individuals with severe mental illnesses. Some focus on actual housing development by employing regional housing developers; others focus on housing access by administering their own Section 8 set-aside programs or through collaborative arrangements with local public housing agencies. A review of the information from the SFY 2006 regional plan applications reveals that:

- There are currently 466 units/beds in 43 projects operated by the Regional Boards;
- All regions operate housing projects that provide residential support;
- Six regions operate a Tenant Based Rental Assistance program;
- Nine regions have organized formal supported housing programs;
- Ten regions report having developed a regional housing plan; and
- Thirteen regions provide specialized housing training to agency staff.

State Perspective

KDMHMRS began funding a full-time Statewide Housing Coordinator in 1993 to work with consumers, Regional Boards, and the Kentucky Housing Corporation (KHC) to develop housing options. The Housing Coordinator supports local efforts through:

- Technical assistance with housing support specialists and local housing developers;
- Supportive housing meetings;
- Special training events; and
- Collaboration with the Kentucky Housing Corporation, the Council on Homeless Policy, the Housing and Homeless Coalition of Kentucky, and other key state housing organizations.

Additionally, KDMHMRS collaborates with KHC in two key initiatives:

- The Supportive Housing Specialist position, which is jointly funded by the KHC and KDMHMRS, works to further integrate the housing needs of persons with mental illness into the state housing finance agency's programs. Technical assistance and consultation in developing housing projects is provided to local nonprofits by the Specialist.
- KDMHMRS provides $400,000 in annual funding to KHC to create a "set-aside" account within KHC's Affordable Housing Trust Fund (AHTF). The AHTF was established in 1996 to spur development of new housing projects for individuals with mental health, mental retardation or developmental disabilities, or substance abuse problems. Through December 2004, approximately 63 projects housing the Department's priority populations have been developed. These projects have provided 613 units in a mix of permanent and transitional housing settings.

Although the Regional Boards have developed housing options for their clients, this can never be the central mission of the organization. More partnerships are needed with local public housing agencies, non-profit and for profit housing developers, and other housing and service agencies. The Regional Planning Councils for the HB 843 Commission, non-profit developers and housing advocates have identified the following needs and barriers to housing.

- Consumers need increased availability of affordable housing options throughout the state;
- There needs to be more direct state funding and federal matching monies for housing options that include independent living, transitional housing, halfway houses, group homes, assisted living, supervised apartments and sober housing for individuals in recovery;
- Collaboration should take place with the Kentucky Housing Corporation and other agencies to finance housing developments for consumers;
- There should be increased state funding for housing supports and increased housing options for persons being discharged from state institutions or at risk of institutionalization;
- There is insufficient funding for housing related support services;
- In the rural areas, there is a lack of appropriate housing and nonprofit developers;
- Many persons with a mental illness have experienced legal, financial and eviction problems which exclude them from housing programs;
- Stigma of mental illness remains a problem, excluding persons from some homeless shelters and housing services;
- Waiting lists for Section 8 vouchers are closed or extremely long in most parts of Kentucky.

Performance Indicators and Action Plans may be found at the end of this Criterion

Physical Health System

Regional Perspective

Regional Boards are required to assess the physical health of each consumer they serve. Clinicians and case managers work closely with parents, community primary care physicians, local health departments, other health care providers, and schools to address the overall health needs of adults. Physical health services are available through Medicaid or local "free" clinics that provide indigent health care. A number of regional MHMR Boards have chosen to "partner" with local health providers in developing/constructing clinics with shared space for both mental and physical health. These partnerships have been very successful in better identifying both mental health and physical health problems experienced by members of their community.

State Perspective

The interface of physical health and mental health is of growing importance to providers of behavioral health services. It is well known that a significant amount of behavioral health services are provided in

the physical healthcare arena. Continuity of care across these systems is critical if individuals are going to recover and succeed in establishing chosen roles in the community.

To help focus on improving access to dental and physical health services, a representative of the Department for Public Health was recommended as a member of the Kentucky Mental Health Services Planning Council. That representative has been attending planning council meetings since SFY 03 and contributing valuable suggestions for collaboration between the physical health and mental health system.

Criminal Justice System

Regional Perspective
Regional Boards provide training to a number of entities in the criminal justice system in order to assure persons with severe mental illness are diverted into treatment whenever possible rather than arrested and booked into jail. In Jefferson County the Crisis Intervention Team has been in place for over 3 years and has successfully diverted thousands of individuals into care.

The relationship between Regional Boards and local jails has been enhanced through the delivery of the mental health and suicide prevention training that the Boards have been providing. Funding was also included to provide consultation to the jails, on an as needed basis, to improve jail personnel's response in dealing with inmates with behavioral health needs. Regional Boards reported entering into more formal agreements with their local jails in thirty-one counties across the Commonwealths in FY 2004.

HB 157 was successfully implemented across the state during SFY 2005, which mandated KDMHMRS develop a statewide crisis triage system for local jails to access a qualified mental health professional to complete an assessment of individuals who were at risk of suicide or behavioral health issues. Regional boards received training in conjunction with their local jails regarding the process for utilizing the system and their roles in regards to the management of risk.

State Perspective
Since the implementation of a multi-faceted legislative initiative in 1994, Kentucky has eliminated the use of jails during acute psychiatric crises and the involuntary hospitalization process. Instead, consumers are evaluated in emergency rooms or by staff of Regional Boards. These efforts have:

- Increased understanding of mental illness by emergency responders such as ambulance drivers, paramedics, and peace officers;
- Improved access to evaluation and treatment;
- Improved communication among local peace officers, judges, mental health professionals, other community resources and the general public; and
- Reduced the stigma and trauma of involuntary hospitalization.

KDMHMRS has intensified efforts to build an integrated service system for individuals with serious and persistent mental illness who are involved in the criminal justice system. The need for collaboration among KDMHSA, the Kentucky Department of Corrections, and other stakeholders in our communities' "safety net" to serve persons with mental illness has become an increasingly apparent.

In SFY 02, as the result of a series of investigative reports published in the Louisville Courier Journal related to suicides in local jails, the legislature appropriated $550,000 to KDMHMRS to develop a training curriculum for jail staff to address this issue. During SFY 03, KDMHMRS developed, implemented and monitored this training curriculum on suicide prevention and recognizing the signs and symptoms of mental illness. Regional board staff were trained in a "model curriculum" and then expected to train the staff in their local jails. In addition to this training, Regional Boards were

encouraged to improve their working relationships with the local jails to assure mental health needs were being met for inmates housed in these facilities.

During SFY 2005, KDMHMRS implemented a new project in local jails that established a behavioral health telephonic triage system. Funding was allocated in the 2004 legislative session to establish this system as well as fund the follow-up services that may be indicated. The system includes the availability of a qualified mental health professional 24 hours a day, 7 days a week by telephone, to assess and make recommendations for housing, classification and treatment for individuals booked into jail who may have a mental illness, mental retardation, brain injury or be at risk of suicide. In the case where it is indicated that a person needs to be seen face to face by a mental health professional, response times were built into the system based upon the level of risk assigned.

KDMHMRS will continue to utilize block grant funds to partner with NAMI Kentucky to fund a cross-systems training coordinator during SFY 2006 This position will continue to work across multiple systems (including mental health, mental retardation, substance abuse, corrections, criminal justice training, jailers association, and Kentucky State Police) to advocate for and coordinate training modules for first responders that encounter persons with behavioral health disabilities.

Persons Who are Aging

Regional Perspective
A review of regional SMI plans indicate that Regional Boards are very much involved in activities related to the elderly, have mental health and aging coalitions and provide services to older adults. Activities at the regional level have increased. Approximately thirteen (13) regions report that they have and provide support to a local mental and aging coalition. A majority of the support provided is a designated staff person to attend and participate in coalition activities. One region is involved with a Grandparent Support Group. Regions also provide material for training, sponsor training or have facilities available for meetings and training. Staff also present at coalition conferences.

A summary of types of services provided by the Regional MHMR Boards include:
- One Regional Board provides Adult Day Health Care services in their entire region;
- Six (6) regions provide In Home Services;
- Twelve (12) Regional Boards provide mental health services in nursing facilities and personal care homes.

Other services include: referral to private providers, public education regarding depression in the elderly, mental health and aging training conference, Caregiver support services, Elder Care Task Force, and education services on issues related to elderly and mental health. Five (5) Regional Boards report that they have a designated staff person/unit responsible for providing mental health services to older persons. Eight (8) Regions have older persons as representatives on the Regional Board of Directors**.**

State Perspective
In Kentucky, the elderly (over 60) population represents fourteen percent of adults with a severe mental illness who are served by Regional Boards. In order to promote education, public awareness, and to improve services to the elderly, KDMHMRS has initiated a State Perspective mental health and aging coalition which was established in October of 1999. This coalition remains active and meets on a quarterly basis. The State Perspective coalition, the Kentucky Mental Health and Aging Coalition, has provided funding to local regional coalitions in order to promote education, needs assessment, resource development and public awareness at the Local Perspective.

The KDMHMRS also provides training opportunities through the Mental Health Institute, PASRR Training and Case Management conference on an annual basis. Scholarships are offered to facilitate attendance at the Annual Summer Series on Aging Conference. In conjunction with UK OVAR GEC, the Department provides an annual statewide training to certified PASRR evaluators.

KDMHMRS has established partnerships with other agencies whose mission is to provide services and training for the elderly through serving on boards, task forces and Committees. The groups include but are not limited to: the Summer Series on Aging Planning Board, through the UK Sanders Brown Institute, Aging Work Group for House Bill 843, Alzheimer's disease and related Disorders Council, and Kentucky KinCare Statewide Steering Committee.

The barriers as identified by the HB 843 Older Adults Work Group are a lack of interface between physical and behavior health care, transportation, provision of services in a variety of venues (in-home, clinic site, nutrition site, senior center etc.) due to physical and medical disabilities, and lack of adequate funding for service to the older adult population.

The KDMHMRS priorities would be to continue to sponsor the Kentucky Mental Health and Aging Coalition and the HB 843 Aging Work Group in order to continue to encourage the development of public awareness, training, education and coordination of services for older adults at the state and the Local Perspective.

Services to Persons who are Deaf and Hard of Hearing

Regional Perspective

State Perspective

KDMHMRS employs a Statewide Coordinator for services to the deaf or hard of hearing. This position, in place since 1994, oversees all efforts to improve services for this population. In September 2002, a Program Coordinator was hired to work closely with the Statewide Coordinator. In response to the special accessibility problems of consumers who are deaf or hard of hearing, an Advisory Committee for Mental Health Services for the Deaf and Hard of Hearing was established by KRS 210.031 in 1992. Meeting on a quarterly basis and supported by these staff members, the advisory committee implements and monitors a variety of statewide and local consumer initiatives. Currently, there are 4 Masters level therapists fluent in sign language serving in 4 regions throughout the state and 1 case manager fluent in sign language in the Danville area.

The challenge to KDMHMRS to improve services to persons who are deaf or hard of hearing is contained in a report, "New Directions for Mental Health and Deafness," prepared in June 1998 by consultants to the Advisory Committee and KDMHMRS. The report estimates that approximately 200 adults with severe mental illness, and 90 children with severe emotional disabilities, are deaf and will seek mental health services during a year. The recommendations from this report are listed in the GAP Analysis.

The Department, the Regional Boards, and the Legislature are responding to the challenge of the report. TTY devices have been installed in critical service sites throughout the state, including community mental health centers, state facilities and toll-free crisis lines. Individuals who are knowledgeable in deafness and mental health issues staff a statewide TTY Crisis Line. In addition to the providers, KDMHMRS staff has also received training in their use and in deaf awareness. Limited funds have been made available for interpreters, training and equipment to make local treatment more accessible. Interpreters are routinely available to facilitate the participation of consumers who are deaf or hard of hearing in meetings and conferences.

Kentucky Guidelines for Services for Deaf and Hard of Hearing, Late Deafened, and Deaf Blind People has been disseminated to all fourteen Regional Boards; Rape Crisis Centers, domestic violence staff and substance abuse staff. The Guidelines have been revised and retitled "Kentucky Standards of Care for Deaf and Hard of Hearing, Late Deafened and Deaf Blind People". The revised Standards of Care will be disseminated to all mental health service providers.

The Kentucky Deaf Access Consortium (KDAC) is a partnership between Eastern Kentucky University (EKU), the Office of Vocational Rehabilitation (OVR), KDMHMRS and the Kentucky Commission on the Deaf and Hard of Hearing (KCDHH). It is a consortium to support the four partners in expanding their capacities to serve the deaf and hard of hearing community with remote interpreting via videoconferencing. This consortium, through EKU, received a three-year federal grant in October of 2001.

Services to Persons with Brain Injuries

Regional Perspective
There are currently twenty-five active providers enrolled in the Acquired Brain Injury Medicaid Waiver program. Residential service providers are located in Ashland, Lexington, Louisville, Owensboro, and Paducah. While services are available in the most populous regions of the state, persons in rural communities often have difficulty obtaining the services of an enrolled provider.

Case management services are available statewide under the Traumatic Brain Injury Trust Fund program. Thus, access to financial assistance and case management services are available to eligible persons throughout the Commonwealth.

State Perspective
In 1999, Kentucky initiated two programs serving persons with acquired brain injuries: the Traumatic Brain Injury Trust Fund; and the Acquired Brain Injury Medicaid Waiver program. Today these programs serve a combined total of approximately 1,800 children and adults – less than 1% of those who may be in need of services to overcome the effects of a brain injury.

There are currently two dedicated resources for children and adults with brain injuries in Kentucky: the Acquired Brain Injury Medicaid Waiver Program; and the Traumatic Brain Injury Trust Fund Program. The Acquired Brain Injury Medicaid Waiver Program can serve 110 adults aged 21 to 65 years who meet nursing facility level of care, are financially eligible for Medicaid services, and who show the potential to progress. This intensive rehabilitation program offers fourteen services including case management, day program, supported employment, occupational therapy, speech and language therapy, counseling, behavior programming, companion services, personal care, residential, specialized equipment, environmental modifications, and respite care. The program is not intended to provide long-term care and its emphasis is on improving or restoring an individual's functioning. This program now has a waiting list of over 50 persons.

The Traumatic Brain Injury Trust Fund Program is designed to fill the gaps in service delivery that many people with brain injuries experience. To be eligible, an individual must have a brain injury and must have no other payer source for the needed service or supports, including wrap around services. Case management is provided to all recipients. Benefits to recipients are limited to $15,000 annually and $60,000 per lifetime. The cost of case management services is not deducted from the person's annual or lifetime caps. This program can serve approximately 1500 persons annually and now has a waiting list of over 600 children and adults.

Performance Indicator 1

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase access to targeted case management provided by Regional Boards by at least .2% above number served in 2004.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Penetration Rate- Adults with SMI Receiving Targeted Case Management

Value:	Percent
Numerator:	Number of adults with SMI served by Regional Boards who received a Targeted Case Management service.
Denominator:	2.6 percent of the Kentucky adult census.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that may impact the system.
Significance: This is considered a valuable indicator of the population served and it is representative of the increase in demand for services on a system that has experienced little more than flat line funding for a number of years. It may also represent improvement in appropriate use of the SMI marker in the MIS.

Performance Indicator 2

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Decrease readmissions of adults with SMI, who had been discharged from the same facility with 30 days preceding, from 16% to 14.5 %.
Population: Adults with SMI
Criterion: 1
Performance Indicator: State Hospital Readmission for Adults with Severe Mental Illness / 30 Days

Value:	Percent
Numerator:	Number of admission episodes during the reporting period in which adults with SMI had been discharged from the same facility with 30 days preceding admission.
Denominator:	Total number of admissions of adults with SMI to the facility that occurred in the state fiscal year.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that may impact the system.
Significance: This is considered a valuable indicator of the population served and it is representative of the increase in demand for services on a system that has experienced little more than flat line funding for a number of years. It may also represent improvement in appropriate use of the SMI marker in the MIS.

Performance Indicator 3

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Decrease readmissions of adults with SMI, who had been discharged from the same facility with 180 days preceding, from 50% projected in 2005 to 40%.
Population: Adults with SMI
Criterion: 1
Performance Indicator: State Hospital Readmission of Adults with Severe Mental Illness / 180 Days

Value:	Percent
Numerator:	Number of admission episodes during the reporting period in which adults with SMI had been discharged from the same facility with 180 days preceding admission.
Denominator:	Total number of admissions of adults with the SMI marker to the facility that occurred during the reporting period.

Sources of Information: MIS is the source for actual number served by state hospitals. Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that impact the system.
Significance: This is considered a valuable indicator of the population served and it is representative of the increase in demand for services due to closure of most private psychiatric beds for adults across the state. This indicator has been refined to Adults with Severe Mental Illness (instead of all clients). Further analyses of the data are planned to determine the number of individuals this high percentage of readmissions represents.

Performance Indicator 4

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase percentage of outpatient appointment within 7, 14 and 30 days after discharge 46%, 70%, and 78% respectively.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Continuity of Care--Outpatient Care

Value:	Percent
Numerator:	Total number of state hospital discharges of adults with SMI in which the adult was seen for an outpatient appointment within 7, 14, and 30 days after discharge.
Denominator:	Total number of state hospital discharges of adults with SMI.

Sources of Information: MIS is the source for actual number served by state hospital admissions and outpatient appointments. Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that impact the system.
Significance: This is considered a valuable indicator of the population served. Assurance of a seamless system of care for this population that includes timely, easy access to aftercare from hospitalization is a priority. Ideally, all persons with SMI would be seen within fourteen days of discharge. This indicator allows for more detailed data regarding timeliness of aftercare appointments.

Performance Indicator 5

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.

Target: Increase percentage of adults with SMI who are employed full time from 12.7% in 2004 to 13.5% in 2006.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Percentage of Adults with SMI Receiving Services Who are Employed

Value:	Percent
Numerator:	Number of adults with SMI served by Regional Boards who have an employment status of "employed full time" (32 hours or more per week), "employed part time" (less than 32 hours per week) , or "in armed forces."
Denominator:	Number of adults with SMI served by the Regional Boards.

Sources of Information: MIS is the source of this client demographic data. Department staff creates target based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that impact the system.
Significance: This is considered a valuable indicator of the population served as a key goal for all individuals is meaningful activity during the day including employment.

Performance Indicator 6

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase percentage of adults with SMI who live independently from 68% in 2004 to 69% in 2006.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Percentage of Adults with SMI Receiving Services Who Live Independently

Value:	Percent
Numerator:	Number of adults with SMI served by Regional Boards who are living independently.
Denominator:	Number of adults with SMI served by the Regional Boards.

Sources of Information: MIS is the source of this client demographic data. Department staff creates target based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that impact the system.
Significance: This is considered a valuable indicator of the population served as a key goal for all individuals is to live in preferred residential setting, which often means independently.

Performance Indicator 7

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: The percentage of adults with SMI involved with the justice system and who are in need of mental health services accessing services from the Regional Boards is anticipated at 5.2%.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Percent of Adults with SMI Receiving Services Who Have Contact with the Justice System

Value:	Percent
Numerator:	Number of adults with severe mental illness (SMI) served by Regional Boards who have a primary or secondary source of referral of justice system.
Denominator:	Number of adults with severe mental illness (SMI) served by Regional Boards.

Sources of Information: MIS is the source of this client demographic data. Department staff creates target based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of programming at the Regional Boards.
Significance: An overarching goal of the Department is to ensure that all individuals, in need of mental health services, who are involved with the justice system receive needed services.

Performance Indicator 8A

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase the percentage of available evidence-based practices available to adults with SMI served by the Regional Boards.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Evidence-Based Practices Provided by Regional Boards including: Supported Housing (SH); Supported Employment (SE); Assertive Community Treatment (ACT); Integrated Treatment for Mental Health and Substance Abuse (IT); Illness Management and Recovery (IMR); and Family Psychoeducation (FPEd).

Value:	Percent
Numerator:	Number of Regional Boards providing each EBP for adults with SMI.

Sources of Information: Department staff derives this data from and create targets based upon the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of programming at the Regional Boards.
Significance: All individuals seeking services at Regional Boards have a right to have evidence-based practices available to them. This data has not historically been collected to allow for comparison/trend data.

Performance Indicator 8B

Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase the percentage of evidence-based practices available to adults with SMI from the Regional Boards.
Population: Adults with SMI
Criterion: 1
Performance Indicator: Percent of Adults with SMI Receiving Services Who Receive Evidence-Based Practices

Value:	Percent
Numerator:	Number of adults with severe mental illness (SMI) served by Regional Boards who received each EBP.

Sources of Information: MIS is the source of this client demographic data. Department staff creates target based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that impact the system.
Significance: All individuals seeking services at Regional Boards have a right to have evidence-based practices available to them. This data has not historically been collected to allow for comparison/trend data.

Performance Indicator 9
Goal: To ensure that every Kentuckian has easy and continuous access to the most current treatments and best support services.
Target: Increase the percentage of adults with SMI who receive evidence-based practices from the Regional Boards.
Population: Adults with SMI
Criterion: 1
Performance Indicator: SMI Adult Consumer Perception of Care

Value:	Percent
Numerator:	Percent of adults with severe mental illness (SMI) reporting positively about treatment outcomes.
Denominator:	Total number of responses from adults with SMI on the consumer satisfaction instrument.

Sources of Information: Historical data is limited to a study of consumer satisfaction with services for conducted in 2000. Future collection of this indicator is to be determined within this fiscal year. It is anticipated that the information will be collected from the Regional Boards using a standardized tool.
Significance: The perception of care as reported by consumers of services is a valuable piece of data to ensure that services are meeting the needs of those served.

Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

STATE ACTIONS PLANS

CRITERION 1

Component 1: Consumer and Family Support

The emphasis on recovery is recognized as a priority, and statewide initiatives will focus on issues that directly impact the lives of stakeholders. Initiatives in SFY 2006 will include:

- Strengthening the education of consumers and family members about mental illness;
- Providing consumer wellness and recovery programs;
- Preparing consumers for responsible involvement in meaningful health planning at the state and regional levels;
- The development of consumer leadership within local communities;
- Identifying strategies and coordinating activities that involve mental health consumers and family members in state and regional planning and programs;
- Working collaboratively with NAMI KY and KY CAN on the consultative peer review process and training;
- Working collaboratively with NAMI KY and KY CAN to provide access and availability to technology for consumer and family members;
- Developing a brochure about grievance procedures;
- Improving access to "Ticket to Work" and other employment initiatives; and

- Maintaining communication with consumer and family advocates.

    - **State Objective A-1-1:** Support the Peer Review process coordinated by KY CAN

Component 2: Emergency Services

Emergency Services
KDMHMRS is committed to assuring that each Regional Board serves as the "safety net" for persons with mental illness who may be in crisis. The foundation for the establishment of a responsive, effective, and efficient crisis response system of care is currently built upon the 24-hour crisis telephone services and the availability of qualified mental health professionals to screen persons for involuntary psychiatric hospitalization.

A flexible array of crisis services is needed in each region in order to meet the diverse needs that consumers in crisis may be experiencing. For this reason, KDMHMRS is very interested in outcomes related to the recent development of a more flexible crisis stabilization service in one region of the state. This region created a " flexible crisis stabilization program" by utilizing their allocation for a crisis stabilization unit to fund four crisis case managers (who are available 24 hours a day, 7 days a week), as well as to purchase crisis beds in various locations in their region.

Some Specific Needs Identified include:
- Additional crisis case management staff;
- Assertive community treatment;
- Additional mental health professional to evaluate individuals seeking voluntary; hospitalization after hours
- Additional crisis stabilization beds;
- Additional training for first responders;
- Additional funding would be needed to assure a full array of crisis services in each region.

Currently KDMHMRS is re-evaluating the role of crisis stabilization units in each region. Kentucky is experiencing a reduction in private psychiatric bed availability, in addition to a reduction in funding for our state operated and state contracted hospitals. As the number of inpatient psychiatric beds continues to be reduced, the role of crisis stabilization units becomes even more critical to meeting the needs of persons with mental illness who may be experiencing a crisis.

- **State Objective A-1-2:** Assist Regional Boards in implementing and monitoring crisis stabilization programs thorough statewide technical assistance meetings.
- **State Objective A-1-3:** Assist Regional Boards and local jails in the development, implementation and monitoring of behavioral health jail telephonic triage system.

Component 3: Mental Health Treatment

Continuity of Care/ Reduction in Inpatient Psychiatric Care
Assurance of a seamless system of care for consumers is a high priority for KDMHMRS. Fragmentation of service delivery can have widespread impact on the quality of consumers lives, as well as an increased readmission rate to inpatient facilities, contact with the criminal justice system, a reduction in level of functioning, and a whole host of other ramifications. A need for strong collaboration among KDMHMRS, the state hospitals and local community mental health centers is needed to assure that individuals do not 'fall through the cracks" of the system.

KDMHMRS uses a number of strategies designed to improve continuity of care including:

- Participating in continuity of care meetings convened by the four state hospitals;
- Producing a quarterly continuity of care report showing data trends; and
- Focusing on continuity of care issues in state hospital and Regional Board monitoring.

❖ **State Objective A-1-4**: Assure and monitor the development of Memorandums of Agreement between state operated/state contracted hospitals and Regional Boards.

Outpatient Services

In addition to providing funding, KDMHMRS and the Regional Boards use the following strategies to insure that integrated mental health treatment services are available as consistently as possible across Kentucky's fourteen mental health regions:

- Supporting the use of new assessment software applications such as LOCUS to insure consistent assessment of levels of care;
- Promoting the use of evidence-based treatment guidelines such as medication algorithms and dialectical behavior therapy;
- Recruiting of Advanced Registered Nurse Practitioners (ARNPs) who can prescribe medications in association with a psychiatrist;
- Establishing standards for ensuring continuity of care across treatment settings.
- Mandatory training for all adult service case managers and their supervisors includes a two-hour training session on co-occurring disorders;
- The Kentucky School for Alcohol and Drug Studies and the Mental Health Institute provide training on co-occurring disorders for consumers, family members and providers.

❖ **State Objective A-1-5:** To promote integrated treatment for persons with co-occurring disorders, provide at least one statewide training opportunity on Motivational Interviewing techniques.

Component 4: Specialized Mental Health Treatment

Case Management

Although adult case management services are available in all 120 counties in the state, access to services is inconsistent and sometimes inadequate to meet the need. The statewide average in SFY 2004 for access to targeted adult mental health case management was 7.8%, ranging from 3.8% in one region to 32% in another.

The delivery of quality, timely case management services is challenged by a number of factors including:

- The current billing system considers four contacts per month a unit of service. Contacts above or below this figure are not reimbursed;
- Kentucky Medicaid rates for case management were capped during SFY 03 and continued to be capped in SFY 2004 (due to deficits in the overall state Medicaid program); and
- Turnover among case managers is high; in general case managers have less status than outpatient clinicians and this "service" is often viewed as an entry level position.

KDMHMRS will use the following strategies to improve case management services

- Provision of initial and ongoing technical assistance and consultation to case managers and their supervisors;
- Coordination of an adult mental health case management advisory faculty to assist with case management training and curriculum development;

- Sponsorship of advanced training opportunities such as the annual Case Management Level II training; and
- Participation in the statewide case management work group to explore opportunities for developing and implementing new training technology;
- Promotion of evidence-based or "best" practices (such as Assertive Community Treatment).

    - ❖ **State Objective A-1-6:** Develop a pilot project for web-based Case Management Training by June 30, 2006.

    - ❖ **State Objective A-1-7:** Develop Case Management Standards of Care in collaboration with DMHMRS, DMS, Regional Boards, consumers, and family members.

Rehabilitation Services

Identified priorities include:

- Dissemination of information about evidenced based practices including psychiatric rehabilitation and supported employment to community support program directors with stakeholder meetings established to support adoption of a consistent and effective statewide model;
- Access to effective rehabilitation and supported employment training and supervision including best practices technology in community support program director meetings and the annual mental health institute;
- Planning and participation in regulatory changes regarding the community mental health center regulation;
- Utilizing data from the Multnomah Community Ability Scale (MCAS) for program evaluation to be distributed to the CSP directors.

Strategies include:

- Provision of initial and ongoing technical assistance and consultation to regional CSP directors and TRP directors;
- Planning and coordination of the quarterly community support program directors meeting to include best practice information, support, and collaboration;
- Partnership with advanced training opportunities such as the annual mental health institute training;
- Coordination and implementation of a Kentucky Recovery Initiative to transform our rehabilitation service system to a recovery oriented system of care through a time-framed plan with stakeholder participation;
- Promotion of evidence-based or "best" practices (such as supported employment, psychiatric rehabilitation, and integrated treatment);
- An additional strategy that has been very successful is the sponsorship of regional staff in securing their International Association of Psychosocial Rehabilitation Services (IAPSRS) credentials. In SFY 03, 30 regional staff and 18 in SFY 2004 availed themselves of the opportunity to take the IAPSRS test. It has been a goal of the DMH to increase the number of certified rehabilitation staff at the local level.

    - ❖ **State Objective A-1-8:** Implement the Multnomah Community Ability Scale functional assessment tool for all adults identified as SMI within the Regional Board treatment system in SFY 2006.

Housing

The Department embraces a "Supported Housing" approach to providing housing options for adults with severe mental illnesses. Supported Housing involves the linking of affordable, permanent, community-based housing options with flexible services and supports. It also assumes that individuals have preferences and should be involved in choosing where and with whom they live. CMHS Block

Grant funds have been critically important to the development of affordable housing while promoting linkages with housing related supports such as skills training, assistance in securing subsidies, and housing search activities.

KDMHMRS strategies to increase the percentage of consumers who live independently include:
- Establishing an email newsletter to disseminate housing information to statewide contacts;
- Promoting rental assistance program development;
- Providing training events on supportive housing and the subsidized housing delivery system;
- Participating in HB 843 and Olmstead planning activities;
- Providing technical assistance to local nonprofit housing developers through referral to KHC's Supportive Housing Specialist.

❖ **State Objective A-1-9:** Support the development of additional supportive housing units in the state by collaborating with the Kentucky Housing Corporation, the Housing and Homeless Coalition in Kentucky, the Council on Homeless Policy, and other key state housing organizations in the two-year Corporation for Supportive Housing initiative.

Physical Health System

While Medicaid provides a significant benefit for physical health care for many individuals with severe mental illness, many still do not have access to care. Individuals still visit hospital emergency rooms for routine physical health care. Other challenges include:
- Inability to afford costly physical health medications;
- Lack of follow-up by consumers with prescribed health regimens for chronic conditions (e.g. diabetes, heart disease);
- Limited formal agreements between primary care settings and Regional Boards; and
- Few examples of physical health and mental health service integration.

KDMHMRS encourages the use of formal or informal agreements between Regional Boards and local primary health care providers. It also monitors for the quality of care provided in assessing and arranging for the treatment of physical health conditions among individuals with mental illnesses. Ultimately, the development of performance indicators is necessary to insure that a consistent level of attention to physical health care needs is provided.

❖ **State Objective A-1-10:** Identify a methodology to assess the strength of the partnership between regional boards and their local health department.

Criminal Justice System

Ideally a full array of diversion and reentry programs would be available in communities to effectively serve adults with mental illness who interface with the Criminal Justice System. Specialized training for law enforcement utilizing the Crisis Intervention Team model, Mental Health Courts and reintegration planning are vital components in the development of interventions to reduce the likelihood of a person with severe mental illness cycling between the two systems.

Effective diversion and reintegration programs do put an increased burden on local providers since persons with severe mental illness are diverted into the mental health system rather than continuing to move into the criminal justice system. In times when resources are limited, many boards have struggled with finding effective ways to serve this challenging population.

The lack of a clearly identified funding source for jail based mental health care has been a long-standing barrier in the Commonwealth. Existing statutes conflict. One stipulates that the local jail is responsible for the payment of mental health care; another states that the Commonwealth is

responsible for the payment of this service. The passage of HB 157 and the establishment of the telephonic crisis network for local jails will improve communities' ability to identify and to treat individuals with severe mental illness who interface with the criminal justice system.

- ❖ **State Objective A-1-11:** Design and implement a sustained training program for Regional Board staff and their criminal justice collaborators on the interface of the behavioral health system and the criminal justice system.

Persons who are Aging

To continue to promote public awareness and education of the mental health needs of older adult the following objective was chosen.

- ❖ **State Objective A-1-12:** Fund at least 2 local coalitions to provide public awareness and education activities.

Persons who are Deaf and Hard of Hearing

Existing Barriers/Challenges to service delivery to this population includes:

- Funding sources
- Qualified staff proficient in sign language
- Culturally appropriate mental health services

KDMHMRS has identified the following areas for future development

- Establish residential treatment program for deaf children;
- Inpatient mental health units for adults and children who are deaf and experiencing acute mental illness;
- Psychiatric/substance abuse inpatient treatment program;
- Hiring a case manager, interpreter and Masters Level therapist as a "team" concept for each quarter of the state;
- Manage mental health interpreting services under a single statewide contract that is coordinated by the state mental health agency;
- Accessible housing for people who are deaf and have a mental illness
- Deaf therapeutic foster homes.

- ❖ **State Objective A-1-13:** Provide at least one in-service training related to serving the Deaf and Hard of Hearing population**.**

Persons with Brain Injuries

The Traumatic Brain Injury Trust Fund Board of Directors (the Board) initiated a strategic planning process by establishing a planning work group in February 2004. The planning group included stakeholders from across the brain injury community, including persons with brain injury, family members, service providers, and state agency personnel.

The Strategic Plan is designed to serve as a road map for the development of services and as a tool for responding to the continuously changing needs of citizens of the Commonwealth whose lives have been forever altered by an acquired brain injury. There are four broad goals in this strategic plan. The objectives under each goal are specific activities that will lead to the accomplishment of the goal. The plan outlines goals and objectives for a five-year period, and is an evolving document that the Board will review annually. The established goals are:

- **State Objective A-1-14:** Seek legislative action to require the helmets when riding bicycles, motor cycles, and ATV's, as well as legislation rendering the failure to use seat belts as a primary offense.

The Traumatic Brain Injury Trust Fund Board of Directors is now working with the Cabinet for Health and Family Services toward the adoption of the Strategic Plan as the template for the further development of services for persons with brain injury in the state.

Comments from Mental Health Planning Council meeting on August 18, 2005:

Comment: Make sure it is clearly stated that so many private psychiatric beds have closed.
Response: It is stated in a couple of places throughout but staff will review and make sure it is clearly stated.

Comment: Regarding Performance Indicator A 1-2a, State *Hospital Readmission Rate of Adults with SMI*, Council suggested changing 06 target from 13 to 14.5%.
Response: Staff agreed to change 06 target to 14.5%.

Comment: Medicaid has to provide funding for In-home services to adults with SMI if they truly want to lower hospital admissions. They need to fund, TR programs, additional outreach services need to be made available such as; home health, drop-in consumer services; and voluntary wrap around services in the community. Kentucky has a long way to go.
Response: Comments acknowledged.

Comment: Does Performance Indicator A1-6 Percents of Adults with SMI and receiving community mental health services who are living independently include personal care home residents?
Response: No, personal care home residents are not considered living independently. Staff discussed how data is collected.

Comment: Regarding A 1-9 the Emergency Preparedness Grant needs to be looked at in conjunction with Housing.
Response: Comment acknowledged, staff will follow through.

Criterion 2: Estimates of Prevalence and Treated Prevalence and Mental Health Systems Data

This plan describes how quantitative population targets are to be achieved through the implementation of the mental health system, including estimates of the numbers of individuals with severe mental illness in the state (or prevalence rates) and the numbers of such individuals served.

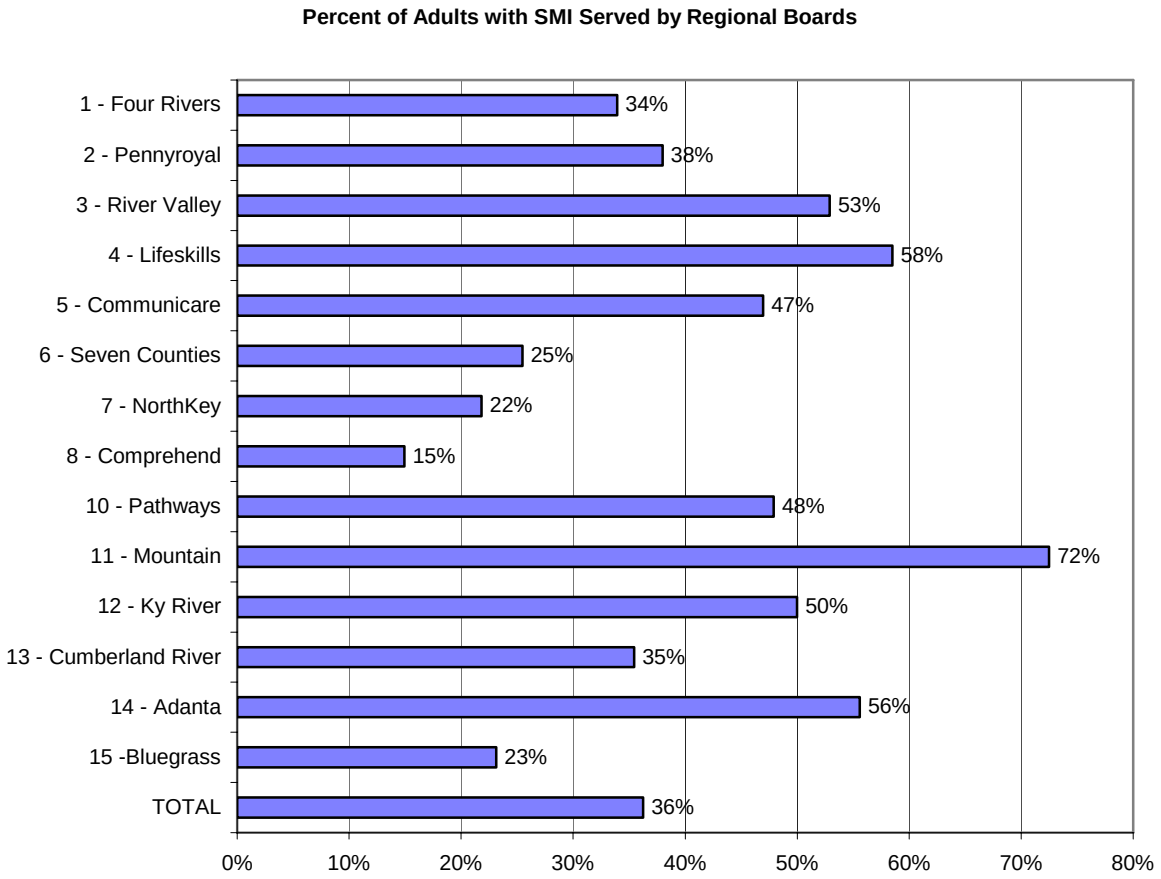
Goal: To increase access to services for adults with severe mental illness.

Component 1: SMI Prevalence

REGIONAL PERSPECTIVE

The following table uses the federal SMI prevalence rate and 2000 census data to estimate, by mental health region, the number of Kentucky adults with SMI using the federal definition. That estimate is compared to the number of unduplicated adult clients with severe mental illness served by the Regional Board during SFY 2005. A resulting regional penetration rate is calculated.

Regional Boards	Adult Census 2000	Federal SMI Estimation	Kentucky SMI Adults Served	Penetration Rate
Four Rivers	157,510	4,095	1,389	34%
Pennyroyal	154,361	4,013	1,524	38%
River Valley	155,001	4,030	2,132	53%
Lifeskills	193,083	5,020	2,936	58%
Communicare	177,804	4,623	2,171	47%
Seven Counties	654,224	17,010	4,335	25%
NorthKey	286,137	7,440	1,624	22%
Comprehend	41,452	1,078	161	15%
Pathways	162,796	4,233	2,027	48%
Mountain	121,476	3,158	2,289	72%
Kentucky River	91,201	2,371	1,185	50%
Cumberland River	177,872	4,625	1,639	35%
Adanta	147,152	3,826	2,127	56%
Bluegrass	526,882	13,699	3,169	23%
TOTAL	**3,046,951**	**79,221**	**28,708**	**36%**



STATE PERSPECTIVE

Kentucky's earliest estimates of the prevalence of severe mental illness were based on national work. In 1980, the U.S. Department of Health and Human Services (USDHHS) estimated that 3.14 percent of the population had some level of mental disorder, and that 0.75 percent of the population had a mental disorder that causes prolonged disability.

With the passage in 1992 of P.L. 102-321, the Community Mental Health Services Block Grant, Congress required the Center for Mental Health Services (CMHS) to develop a national definition for "adults with severe mental illness." CMHS was further required to develop an "estimation methodology" based on the definition that state mental health agencies must use to estimate needs in their state plans. While P.L. 102-321 limits CMHS Block Grant spending to persons who meet the federal definition, it does not require states to serve everyone covered by the definition. The federal definition of "adults with a severe mental illness" was published on May 20, 1993.

Early planning in Kentucky for adults with severe mental illness, using the 0.75 prevalence rate for adults with persistent disability, estimated that approximately 28,000 adults in Kentucky should be the priority population for services. Kentucky's mental health planning has historically focused on this subset of the population in development of its Community Support Services plan.

A work group comprised of consumers, family members, and providers reviewed the federal definition and Kentucky's statutory definition of "chronic mental illness"; its recommendations were reflected in Administrative Regulations published in 1994. The regulation provided for operational definitions of the target population of adults with severe mental illness consistent with national policy.

Kentucky's definition of "adult with severe mental illness," as currently operationalized, uses the following criteria for age, diagnosis, disability, and duration: Kentucky's definition is narrower than the definition promulgated in the federal register for "Adult with Severe and Persistent Mental Illness." Historically, stakeholders have supported the Department's desire to focus limited funding on adults who meet the state's narrower definition.

Variable	Criteria
Age	Age 18 or older
Diagnosis	Major Mental Illness • Schizophrenia (DSM 295.xx, 297.1, 298.9) • Mood Disorder (296.xx) • Other (DSM _____) within State and Federal Guidelines for Severe Mental Illness
Disability	Clear evidence of functional impairment in two or more of the following domains: • Societal/Role Functioning: Functioning in the role most relevant to his/her contribution to society and, in making that contribution, how well the person maintains conduct within societal limits prescribed by laws, rules and strong social mores. • Interpersonal Functioning: How well the person establishes and maintains personal relationships. Relationships include those made at work and in the family settings as well as those that exist in other settings. • Daily Living/Personal Care Functioning: How well the person is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the person's age, gender and culture. • Physical Functioning: Person's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries. • Cognitive/Intellectual Functioning: Person's overall thought processes, capacity, style and memory in relation to what is common for the person's age, gender, and culture. Person's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating.
Duration	One or more of these conditions of duration: • Clinically significant symptoms of mental illness have persisted in the individual for a continuous period of at least two- (2) years. • The individual has been hospitalized for mental illness more than once in the last two- (2) years. • There is a history of one or more episodes with marked disability and the illness is expected to continue for a two-year period of time

The 1999 federal methodology for estimating adults with serious mental illness requires states to use the national estimate of 5.4 percent for the prevalence of adults with severe mental illness, and a rate of 2.6 percent for adults with severe and persistent mental illness (SMI).

Component 2: Mental Health Systems Data

REGIONAL PERSPECTIVE

At the local Regional Board level, outcome instruments are being used for program evaluation, identification of staff training needs, and client treatment planning. Consumers, Regional quality assurance staff, Community Support Program directors and Department staff have cooperated in the

development of useful reports from the outcomes data. These reports will soon become available on the Department's web site for their use.

STATE PERSPECTIVE

The Cabinet for Health and Family Services, as part of the Executive Branch strategies statewide, is moving toward performance-based contracting. Therefore, the Department continues planning with its primary contractors, the Regional Boards, to measure and manage organizational performance and clinical/personal outcomes. The Regional Boards remain essential partners with the Department, as well as with consumers, families, and advocates, in identifying what outcomes need measuring, what instruments are appropriate for measuring those outcomes, and what resources are required for implementing the measures. A significant amount of outcomes data collection occurs now as a result of that collaboration. The improvement of these data sets and the addition of new measures will complement what is already in place.

For over ten years, the Department has been building a system to structure and house data. Within this system, the Department continues to review and improve the quality of datasets collected monthly from Regional Boards and the state hospital facilities. These datasets include:

- Client, Event, and Human Resources data from Community Mental Health Centers;
- State hospital facility Admission and Discharge Data.

The Division of Mental Health has been addressing the issue of outcomes for the two main populations they serve: Adults and Children. The following addresses specific outcomes initiatives within the Adult Mental Health Services arena*:*

- *Brief Psychiatric Rating Scale (BPRS) for Crisis Stabilization Consumers* which is currently administered upon consumer admission and discharge of each Crisis Stabilization Unit
- *Multnomah Community Ability Scale and the Medical Outcomes Study Health Status Survey for SMI consumers* which is administered upon client admission and at consequent six-month intervals. Implementation of the use of the instrument will extend over a three-year period. The selected population will be consumers of Therapeutic Rehabilitation Services in the first year, will expand to include consumers of Case Management Services in the second year and expand to all remaining SMI consumers in the third year.
- *University of Kentucky Behavioral Health Satisfaction Tool for Outpatient Consumers*
  This tool includes three instruments and is annually administered to 5% of consumers served:
  - Kentucky Consumer Satisfaction Survey;
  - The 21 item Mental Health Statistics Improvement Program Survey; and
  - Medical Outcomes Study Health Status Survey.
- *Medical Outcomes Study Health Status Survey*
  Completion of this tool is voluntary for consumers who have severe mental illness and are served through Therapeutic Rehabilitation Programs.

PERFORMANCE INDICATOR 1

Goal: To increase access to services for adults with severe mental illness.

Target: Increase the percentage of adults with SMI who receive services from the Regional Boards from 36.3% to 38.5%.

Population: Adults with SMI

Criterion: 2

Performance Indicator: Penetration Rate--Adults with Severe Mental Illness

Value:	Percent
Numerator:	Number of adults with SMI served by the Regional Boards.
Denominator:	2.6% of the total number of adults per Kentucky 2000 census.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that may impact the system.
Significance: This is considered a valuable indicator of the population served and it is representative of the steady increase in demand for services on a system that has experienced little more than flat line funding for a number of years. It may also represent improvement in appropriate use of the SMI marker in the MIS.

Performance Indicator 2

Goal: To increase access to services for adults with severe mental illness.
Target: Increase the percentage of adults with SMI who receive services from the Regional Boards.
Population: Adults with SMI
Criterion: 2
Performance Indicator: Penetration Rate--Older Adults with Severe Mental Illness

Value:	Percent
Numerator:	Number of adults age 60 and over, with SMI, who received services from the Regional Boards.
Denominator:	2.6% of the total number of adults age 60 and over per Kentucky 2000 census.

Sources of Information: MIS data is used for actual numbers of adults. Department staff also utilize information provided by the Regional Boards (Plan and Budget Form 122 & 123) to set targets.
Significance: Kentucky's older adult population is the fastest growing segment of the population and older adults with SMI often do not seek the services they need.

Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

ACTION PLANS

Criterion 2

Component 1: SMI Prevalence

A review of the information from the SFY 2006 regional plans reveal that:
- All fourteen regions described their process for coding SMI.
- Only two regions exhibit variances of more than one standard deviation from the statewide average (penetration rate) and are actually higher than the statewide average. This is an improvement over last year when one-half of the regions were out of range (more than one standard deviation from the statewide average).

A wide variety of penetration rates is apparent across the state and it appears that the diversity is due to the availability of alternative resources. For instance, in an urban area, private psychiatric providers would likely be utilized by a higher proportion of adults with severe and persistent mental illness, than would be the case in rural areas. However, the variation in penetration rates, reported by the Regional Boards, does not lend itself to this interpretation. The Department has an interest in applying a consistent definition of "adults with severe mental illness" to improve the quality of information on this priority population. Accuracy of coding is monitored by medical record reviews during periodic Status Assessments of mental health services provided by Regional Boards.

In addition, statistical indicators that rely on the number of adults with an SMI marker are increasingly used to assess performance and outcomes. As a result, Regional Boards and the Department are increasingly interested in the consistent and accurate use of the marker in their data sets.

As the KDMHMRS moves toward the use of performance indicators and performance contracting, the issue of identifying individuals with severe mental illness in clinical records and in the client data set becomes increasingly important.

Regional Boards have adopted a number of strategies to more accurately identify individuals as meeting the KDMHMRS definition of severe mental illness. These include:

- Increased training of clinicians;
- Routine chart reviews;
- Changes in intake and update procedures.

❖ **State Objective A-2-1:** Continue to collaborate with Regional MHMR Boards in exploring their processes for accurately and consistently identifying adults with severe mental illness who receive community mental health services.

Component 2: Mental Health Data

Uniform Reporting System - Kentucky can report overall 62% completion and 38% partially completed on the 21 tables. Figure 1 provides a glance at the status of Kentucky reporting in the Uniform Reporting System tables. The majority of the 38% partially completed tables pertain to evidence-based practice information. In recognizing the need for continued assistance in this area, SAMHSA has developed a workgroup to study further what evidence-based practice information is needed at the Federal level and what related evidence-based practice information states can submit. This workgroup has stated that the information requested in the current evidence-based practice tables may change in the upcoming years. Kentucky will make every effort to attain the information as requested in the tables. One step toward doing so is that our State Planner participates in the Evidence-Based Practice Workgroup conference calls.

Quality Assurance - Currently, the Division of Mental Health has a process that facilitates information exchange and maintains continuity and relational values among data sets. The Joint Committee on Information Continuity (JCIC) is the committee that establishes policies and procedures for this purpose. In addition, with the recent reorganization of KDMHMRS a new Quality Assurance Branch has been created that will focus on the development of standards and measurement of outcomes for the entire department.

Resources Needed to Implement Evidence-Based Practices -Currently, additional resources are needed to support more extensive use of clinical evidence based practices. Kentucky currently does not have in clinical practice several of the evidence based practices as listed in the Uniform Data Reporting System.

Costs - Processes developed for applying the BPRS and the MCAS are in place so that instrument usage stands alone of any further shrinking of available resources. The application of the MHSIP Consumer Survey is currently being conducted as a result of the Data Infrastructure Grant. Kentucky will plan to work with Regional Boards to set in place a process to annual collect and process the MHSIP survey data as well as reduce the Boards' costs of having to meet related JACHO requirements.

Identification of Clients - Currently, the Cabinet can not identify clients served in order to conduct quality performance surveys such as the MHSIP Consumer Survey. Having access to this information means further working with the contracted Regional Boards and adjusting data base structures to include this information.

Data Warehouse - Linking mental health data with other agency data such as public health, education, or justice system currently requires project level Memorandum of Agreements. Kentucky would like to work toward establishing a data warehouse to make available information to agencies who share common goals.

Analysis of Multiple Data Sets - The Division of Mental Health and Substance Abuse Services is working with the Department for Community Based Services (DCBS), the Department for Public Health, Department of Corrections and the Department for Juvenile Justice to develop methods for sharing data without breaching confidentiality. Utilization of private psychiatric hospital beds by Regional Board clients is a major subject for analysis during the coming fiscal year. Comparison of data on children by DCBS and children served by KDMHMRS is also planned to assist DCBS in complying with their federally-recognized Performance Improvement Plan. Additionally, involvement in the criminal justice system by adults and children is the subject of another study. These efforts are part of the federally funded "Data Infrastructure Grant" project.

Uniform Reporting System - Kentucky is applying for the State Data Infrastructure Grant in order to accomplish the three objectives:

- To be able to complete 100% of Uniform Reporting System tables (21) by September 2007;
- To continue to improve the quality of the data submitted by the Providers (14 Regional Boards). This includes continued work with the Research and Data Management Center and the Joint Committee for Information Continuity to improve data reporting in the areas of accuracy and completeness. This also includes regular consultation with a group of Quality Improvement Specialists;
- To further develop outcomes goals within the Division of Mental Health. In addition to having access to the completed Uniform Reporting System data tables, the Division has established performance measures for use in understanding the effectiveness of service delivery across Kentucky. The next step is using this information to develop a deeper understanding of improving service delivery. The Division would like to be able to make further use of the variables collected to benefit community-based delivery systems. The first step includes setting outcomes goals.

Quality Assurance for Outcomes

- The first step to assuring quality outcomes begins with goal three in the above section related to the establishment of Division-wide outcome goals. Second, the Department will to establish a committee for establishing procedures for Quality Assurance as related to outcomes. This committee will most likely involve consumers, Regional Boards, and Department staff.

State Objective A-2-2: KDMHMRS will monitor the MIS for accurate reporting of data.

Comments from the Mental Health Planning Council meeting on August 18, 2005:
There were no comments for this Criterion.

Criterion 4: Targeted Services to Homeless and Rural Populations

The plan provides for the establishment and implementation of outreach to, and services for, such individuals who are homeless and the manner in which mental health services will be provided to individuals residing in rural areas.

Goal: Improve outreach and services to persons who are homeless or live in rural areas of the Commonwealth

Component 1: Homeless Outreach

Regional Perspective
Most Regional Boards offer individualized services designed to alleviate homelessness as well as to provide "mainstream" mental health treatment to persons who are homeless and mentally ill. Regional Boards report in their system of care plans for adults with severe mental illnesses the following level of participation:

- All Regions participate in regional Continuum of Care routine meetings;
- All Regions give a service priority to homeless individuals;
- Seven Regions have staff dedicated to homeless individuals;
- Four Regions do street outreach;
- Eight Regions regularly visit local homeless shelters;
- Nine Regions do consultation with local shelters; and
- Eight Regions have a walk-in clinic.

State Perspective
By combining PATH and other McKinney funds (that support specialized services) with state and federal funds (that support Community Support Services), KDMHMRS and the Regional Boards attempt to provide a statewide system of outreach, community support, and mental health services for persons with severe mental illness who are homeless. The role of the State PATH Coordinator is central to supporting local PATH providers throughout Kentucky. The Coordinator prepares the annual PATH application in collaboration with local providers, insures that annual data collection requirements are met, and insures that fund allocation and contracts are in place. Support is also provided through notification of relevant training, updates on homeless issues, and on-site technical assistance as needed.

KDMHMRS collaborates with the Specialized Housing Resources Department within the Kentucky Housing Corporation (KHC) in the maintenance of local homeless planning boards ("Continuum of Care Committees") in Kentucky's area development districts (which correspond to the fourteen mental health regions). Regional Boards are encouraged to participate in this process for the benefit of individuals with severe mental illness who are homeless or may become homeless in their regions.

KDMHMRS provides state funds to the St. Johns' Day Center in Louisville to hire an outreach worker. This staff person provides on-site assessment and links individuals with services at Seven Counties Services, the Regional Board for Louisville. During SFY 2006, CMHS Block Grant funds will continue to support a Rural Homeless Outreach program in the Mountain Regional Board area. The goals of this program will be the identification and linkage of individuals with serious mental illness who are homeless with mainstream mental health services and the provision of consultation and training to homeless service providers. The service providers will primarily be members of the region's Continuum of Care group charged with developing regional, collaborative strategies to serve the homeless.

KDMHMRS has collaborated with the Kentucky Council on Homeless Policy in developing a Statewide Homeless Prevention Plan. This plan is designed to adopt policies and strategies to improve access to mainstream services for people experiencing homelessness. Recommendations include such areas as:

- Coordination of services;
- Planning Strategies;
- Procedural processes;
- Training needs; and
- Funding.

KDMHMRS has also been collaborating with the Kentucky Council on Homeless Policy in developing a ten-year plan to end chronic homelessness in Kentucky. Staff within the Division of Mental Health and Substance Abuse have played a principal role in identifying barriers to receipt of mainstream mental health and substance abuse services by individuals who have been chronically homeless. Recommendations include such areas as:

- Affordable Housing;
- Services;
- Discharge Planning;
- Coordination of Resources; and
- Economic Limitations.

Performance Indicators and Action Plans are found at the end of this Criterion

Component 2: Rural Outreach

Regional Perspective

A number of initiatives have been established at the Regional Board level to address rural issues. CMHS Block Grant funds continue to be allocated to rural areas to maintain housing developer positions. These staff persons are responsible for improving access to existing housing as well as developing additional housing opportunities for adults with severe mental illness. Rural housing developers have been focusing on applying for and administering set-asides of rental assistance funding to be targeted to adults with mental illness residing in rural counties. A number of housing funding sources have been accessed including HOME funds, Emergency Shelter Grant funds and Shelter plus Care funds. These initiatives have allowed Regional Boards to tailor rental assistance programs to local needs.

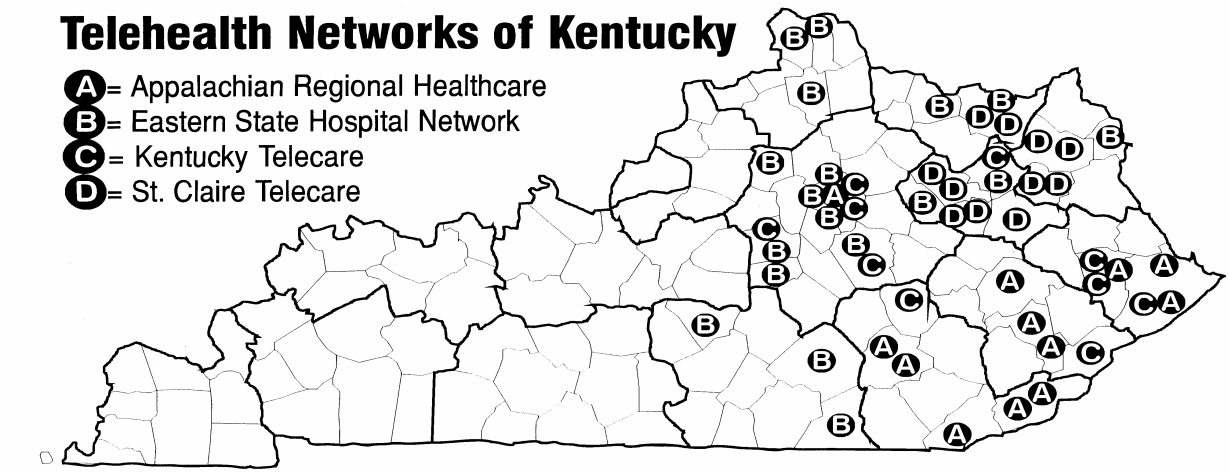
Ten of fourteen Regional Boards report engaging in initiatives to better coordinate transportation services in their regions. The Bluegrass Regional Board maintains a teleconferencing/telepsychiatry network across the four regions within the Eastern State Hospital district. Telehealth is used for discharge planning meetings between ESH and outpatient offices. The University of Kentucky is also using telemedicine to communicate with local clinics in Eastern Kentucky. An initiative of the 2000 Kentucky General Assembly established a Telehealth Board, which established standards and enabled billing for telehealth services.

Four Regional Boards now report delivering or accessing services from the telehealth network and for very limited uses (e.g. screening for case management services upon discharge from state facilities).

- Pathways, Inc., has obtained the equipment and is looking at using this in remote counties;
- Kentucky River Community Care, Inc., has several sites equipped for video conferencing. Two sites are a part of the Appalachian Regional Healthcare network and one site is a part of the Centernet network. They have business meetings, Olmstead meetings, case conferences, trainings and other events over these networks but have not started providing direct client services over these networks since protocols have not yet been established;

- Bluegrass Regional Board uses Telehealth for discharge planning meetings between ESH and outpatient offices, and is finalizing billing instructions to enable an expanded use of this service. Bluegrass also utilizes trainings from the University of Kentucky's TeleHealth network for continuing education of staff and general grand rounds.

A map showing the availability of “telehealth” in eastern Kentucky, where access is most problematic, may be found below.



State Perspective

Using the definition of Standard Metropolitan Statistical Area, and information from the 2000 Census, Kentucky has 27 counties considered urban and 93 considered rural. Approximately 44% of the state’s population resides in its 93 rural counties.

Transportation barriers remain one of the greatest concerns among providers, consumers and family members. The Human Service Transportation Delivery Program pools existing public transportation funds including Medicaid non-emergency transportation. A total of 16 transportation regions statewide operate 24 hours a day/seven days a week with a single broker or broker/provider established in each region. Consumers access transportation services through a toll-free phone number.

Rural communities often have fewer staff and resources to provide mental health services. It is important for rural mental health agencies to develop collaborative agreements with primary care physicians, senior citizens centers, church groups, and government agencies. Rural case managers have been resourceful in assisting persons with a severe mental illness in identifying their needs, as well as meeting these needs through the identification and development of local resources, and are critical linkages to formal and informal services and supports in rural Kentucky. Several actions by the Kentucky General Assembly have increased the types and numbers of mental health professionals who can be a Qualified Mental Health Professionals and created licensure for mental health counselors. The KDMHMRS will continue to work with rural communities and other entities in these activities including addressing shared federal, state, and local funding, shared and cross training; and bringing all stakeholders together at the state and local level to strategize best practices.

The advantages of establishing a teleconferencing capability across rural areas are well known. Due to difficulties in recruiting qualified medical and clinical staff to work in more rural areas, teleconferencing can be used to extend staff coverage from a central site to outlying rural clinics and other service sites. Specialized services (e.g. therapists who are fluent in sign language) could be effectively extended through the use of teleconferencing.

Consumers, family members and providers can access resource information via the Internet at KyCares (www.kycares.ky.gov), the online services/information directory and guide for Federal, State and Community Providers, which provides information on basic services like housing, food, childcare, transportation, benefits information, and any number of physical health and behavioral health services.

During SFY 2006, statewide consumer and family initiatives will continue to receive CMHS Block Grant funding to continue to impact on the problems associated with rural isolation, stigma, lack of information and access**:**

- The Kentucky Consumer Advocacy Network's Bridges Program will continue to provide peer support in several rural areas;
- NAMI Kentucky will provide "Family to Family" education in rural counties. A statewide campaign with the faith community has been developed to heighten awareness of the special needs of families and consumers in rural areas. In addition, the Crisis Intervention Team program will be expanded to include rural areas; and
- NAMI Kentucky will target two rural areas for establishment of new local affiliate organizations.

PERFORMANCE INDICATOR 1
Goal: Improve outreach and services to persons who are homeless or live in rural areas of the Commonwealth.
Target: It is anticipated that in 2006 Regional Boards, of the adults with SMI, 3.3% of them will be homeless.
Population: Adults with SMI
Criterion: 4
Performance Indicator: Penetration Rate—Adults with SMI Who Are Homeless.

Value:	Percent
Numerator:	Number of adults with SMI, served by the Regional Boards, who have living arrangement demographic field of " homeless/uninhabitable dwelling" or mission/shelter."
Denominator:	2.6 percent of the 2000 Kentucky adult census served by the Regional Boards.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that may impact the system.
Significance: Regional Boards first reported the demographic for homelessness in 2004. The homelessness population in Kentucky is reportedly growing and national literature indicates that many of them have unmet mental health treatment needs.

PERFORMANCE INDICATOR 2
Goal: Improve outreach and services to persons who are homeless or live in rural areas of the Commonwealth.
Target: It is anticipated that the number of adults with SMI who reside in rural areas will be approximately 45% in 2006 .
Population: Adults with SMI
Criterion: 4
Performance Indicator: Penetration Rate—Adults with SMI Who Reside in Rural Areas of the State.

Value:	Percent
Numerator:	Number of adults with SMI, served by the Regional Boards, who reside in rural (non-MSA) counties.

Denominator:	2.6 percent of the 2000 Kentucky adult census who reside in rural (non-MSA) counties.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 115, 122 &123) and knowledge of various factors that may impact the system. University of Louisville's Data Center is the source of MSA versus non-MSA Kentucky counties.
Significance: This is considered a valuable indicator of the population served and it is representative of the steady increase in demand for services in rural areas. The targets for last year and this year are modest due to the recent (and potentially continuing) changes in which counties of the state are considered rural (non- MSA) versus non-rural.
Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

STATE ACTION PLANS

CRITERION 4

Homeless Outreach

The Kentucky Housing Corporation's (KHC) Housing Needs Assessment 2004 estimates the homeless population to be approximately 1% of the total population, and KHC's Homeless Survey 2001 reported approximately 17% of homeless respondents identified a serious mental illness. With population figures from the 2000 Census, there are an estimated 30,471 homeless adults in Kentucky, and **5,180 homeless adults with a serious mental illness** (at some point in time during a 12 month period). The following table shows this information broken down by region.

Regional Boards*	Adult Census 2000	Homeless Estimation	Homeless SMI Estimation
1. Four Rivers	157,510	1,575	268
2. Pennyroyal	154,361	1,544	262
3. River Valley	155,001	1,550	264
4. Lifeskills	193,083	1,931	328
5. Communicare	177,804	1,778	302
6. Seven Counties	654,224	6,542	1,112
7. Northkey	286,137	2,861	486
8. Comprehend	41,452	415	71
9/10. Pathways	162,796	1,628	277
11. Mountain	121,476	1,215	207
12. Kentucky River	91,201	912	155
13. Cumberland River	177,872	1,779	302
14. Adanta	147,152	1,472	250
15. Bluegrass	526,882	5,269	896
Total	**3,046,951**	**30,471**	**5,180**

The Kentucky Council on Homeless Policy has identified the following barriers to decreasing homelessness.

- Lack of knowledge about the types of resources and process for access;
- Difficulty in keeping existing databases and information sources up to date;
- Non-uniform accessibility to resources in each region;

- No central point of contact for becoming aware of or accessing available resources either at the state or local level;
- No shared philosophy among all social service workers of prevention approach; and
- Difficulty "mainstreaming" homeless persons with severe mental illness into regular mental health programs and other community services operated by Regional Boards and other community agencies.

Additional barriers include:
- No state funds are provided for homeless services;
- Limited residential options that combine permanent housing with on-site supports;
- Although Kentucky received an increase in PATH funding, to $393,000, it is insufficient to address the needs of homeless persons with mental illness in the state.

Priorities identified by the Kentucky Council on Homeless Policy and KDMHMRS include:
- Continued participation in HUD's Continuum of Care process, with increased coordination between agencies;
- Continued outreach to homeless persons with a mental illness;
- Decrease discharges from inpatient facilities to homeless shelters; and
- Expansion of the state PATH program.

During SFY 2006 KDMHMRS will, through the PATH Formula Grant, support specialized initiatives to complement the existing community support array in the three urban regions (Lexington, Louisville, and Covington) and two rural regions (Kentucky River and Adanta). PATH programs will provide the following services:
- Outreach, housing, case management and psychiatric clinic services in a large homeless shelter in Lexington;
- Outreach, housing and psychiatric clinic services in Covington;
- Payee ship and case management services within a homeless service organization in Covington;
- Residential support within a transitional facility for homeless men with severe mental illness in Louisville;
- Case management and residential support in the Kentucky River Region; and
- Outreach and housing support services in the Adanta Region.

KDMHMRS staff and Regional Board staff use a number of strategies to insure that individuals with serious mental illnesses who are homeless are evaluated and receive necessary services. These include:
- Identifying individuals who have been homeless more accurately in the client data set;
- Providing accommodations in clinic and other program hours;
- Providing specialized training to case managers and clinicians;
- Establishing formal and informal linkages with homeless services providers; and
- Continued participation in local Continuum of Care meetings.

❖ **State Objective A-4-1:** Collaborate with homeless service providers and other state agencies in implementing the Homeless Prevention Pilot Project, to address the problem of institutional discharge to homelessness.

Rural Outreach

The President's New Freedom Commission on Mental Health recommends improving access to quality care in rural and geographically remote areas. The Kentucky Commission on Services and Supports for Individuals with Mental Illness, Alcohol and Other Drug Abuse Disorders and Dual Diagnosis (HB 843)

recommends addressing the issues of transportation, the availability of trained professionals, and the availability and utilization of telehealth and distance learning technology to reduce the isolation in rural areas.

Common problems for rural areas are isolation and the difficulties imposed by the lack of information and access. Lack of adequate transportation, and in some regions, lack of any public transportation remains the largest barrier to services. Other problems include the heightened stigma associated with mental health services in rural areas and the difficulty in ensuring confidentiality and anonymity in small communities. Regional Planning Councils of the HB 843 Commission identify a lack of sufficient funding and a scarcity of trained professionals as barriers to services in their regions.

Priorities include:

- increasing access to services by increasing transportation opportunities;
- increasing availability of trained treatment professionals;
- increasing public awareness of mental health services; and
- increasing availability and utilization of telehealth to reduce isolation.

❖ **State Objective A-4-2:** Incorporate best practices in rural service delivery into existing KDMHMRS sponsored training events (e.g. MHI, CSP Director, Level II Case Management).

Comments from the Mental Health Planning Council meeting on August 18, 2005:
There were no comments for this Criterion.

Criterion 5: Management Systems

The plan describes the financial resources and staffing necessary to implement the requirements of such plan, including programs to train individuals as providers of mental health services, and the plan emphasizes training of providers of emergency health services regarding mental health. The plan contains a description of the manner in which the state intends to expend the grant for FFY 2004 to carry out the provisions of the plan.

Goal: To assure that the recovery oriented mental health system has:

- ***An adequate number of mental health professionals***
- ***A culturally competent workforce***
- ***Adequate and appropriate training of mental health professionals***
- ***Adequate financial resources***

COMPONENT 1: Staffing Resources

Regional Perspective
Community mental health services in Kentucky are provided by Regional Boards, which are non-profit corporations employing approximately 4000 persons statewide. A small segment of this workforce works exclusively with adults with severe mental illnesses in community support programs. In the recent Plan and Budget submission, Regional Boards were asked to identify staff dedicated to serving adults with severe mental illnesses.

These Community Support Program (CSP) staff include the following:

Region	**SMI Served**	**Case Mgmt.**	**Therapeutic Rehabilitation**	**Outpatient Therapists**	**Total Dedicated CSP Staff**
1	861	6	5	19	11
2	1471	8	5	20	13
3	1623	9	14	4	18
4	2532	16.5	14	51	30.5
5	692	7	17	3	27
6	4959	52	9	49	110
7	1618	6	8	12	14
8	219	3	5	16	8
9/10	1874	12	61.7 *	61.7 *	77.7
11	2170	24	24	17	66.5
12	1290	12	15	6	28
13	1160	9	13	75.5	22
14	2132	17	28	42	45
15	3163	19.8	46.72	179	280

*Combined total of TR and Outpatient staff.

State Perspective
Human resource development is a key component in crafting a quality system of care. The issue of "staffing" is affected by a number of factors including regulations, provider qualifications, training, recruitment and retention. Although the Department does not directly employ or manage the staff of the Regional Boards, the Department is responsible for planning for a workforce to meet the demand for services. Traditionally the Department's role has been indirect, focusing on staff training, technical

assistance and the establishment of minimum qualifications for providers. The Department continues in these roles but has taken on a larger, more direct role in addressing the shortage of behavioral health care providers in the state.

Component 2: Cultural Competency

Regional Perspective
In general, the majority of regions have specially trained staff, who in turn provide cultural competency training at orientation for new staff. Cultural competency is assessed through consumer satisfaction surveys and supervision of employees.

State Perspective
Building on efforts first initiated in SFY 97, the Department remains firmly committed to promoting and supporting a culturally competent workforce throughout its service delivery system (central office, the state operated or contracted facilities and the Regional Boards). To this end, the Department contracts with two highly acclaimed cultural competency trainers to provide "Training of Trainers" courses at least twice a year to staff from Regional Boards and facilities. These courses are based on a continually evolving curriculum developed by the Department and are held at varying locations throughout the state. This strategy has been very favorably received by the Regional Boards and facilities as it allows them to develop their own internal cultural competency training capacity, as well as minimizing out-of-office time on the part of staff and related travel expenses.

Component 3: Major Training Initiatives

Regional Perspective
A review of the information from the SFY 2006 regional plan applications reveals that:
- Twelve of the Regional Boards offer specialized training opportunities to CSP staff;
- Five Regional Boards now have 21 staff that have earned IAPSRS certification; and
- Ten regions have ongoing training initiatives with local colleges or universities that are described in their annual plans.

As one component of the "decriminalization" of mental illness, each Regional Board is responsible to provide education programs to peace officers, emergency service providers, courts, and inpatient psychiatric facilities in their region. Topics included are an overview of the involuntary hospitalization law, the consumer's need for privacy, the importance of using the least restrictive level of restraint, and how to access evaluators 24 hours a day, seven days a week. A curriculum based on the initial decriminalization training for peace officers is included in the yearly training provided to each peace officer in Kentucky, and is included in the training of adult protective service workers for the Cabinet for Families and Children.

State Perspective
KDMHMRS provides, sponsors, or participates in a variety of training initiatives. This includes sponsoring continuing education units (CEUs) for professional board licensure and certification. Many of these initiatives have been referenced in preceding sections but are discussed in detail below.

On an annual basis the Division of Mental Health provides a number of training events. These include:

Division of Mental Health and Substance Abuse Sponsored/Provided Training Events

Type of Training	Intended Audience	# of Participants Anticipated	Frequency/ Length of conference
Case Management Certification Training	Mental Health Case Managers who work with Adults with SMI and their supervisors	Approximately 30 per session	Held 4 times per year for 3 days each
*Mental Health Institute Pre-Conference on Medication Algorithms	Behavioral health providers and administrators, consumers and family members	Approximately 1,000 Approximately 300	Annually 2.5 days 9/27-29/05 9/26/05
*Kentucky School of Alcohol and Other Drug Studies	Behavioral health providers and administrators, consumers and family members	Approximately 1,000	Annually 4.5 days 7/18-22/05
*Question, Persuade, Refer (QPR) Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Varies depending on location across the state	At least four times per year
*Cultural Competency Training of Trainers	Current and prospective providers of Cultural Competency Training at the KDMHMRS operated or contracted facilities and Regional MH/MR Board staff and KDMHMRS central office staff	Approximately 20	Four times per year and upon request
Train the Trainers Suicide Prevention in the Jails	Jailers and Regional MH/MR Board staff	Varies depending on location across the state	At least two times per year
Deaf Awareness Trainings	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Ranges from 5-125 per session	Typically once per month and also on a PRN basis
TTY Assistive Listening Devices Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDMHMRS central office staff	Ranges from 5-125 per session	Typically once per month and also on a PRN basis
What Is Mental Health Training	Kentucky Association for the Deaf	Up to 200	Annually
Domestic Violence and Deafness Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Approximately 60	Annually
*HIV/AIDS Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDMHMRS central office staff	Ranges from 5-125 per session	Annually

Case Management Certification Training

This certification training is provided by KDMHMRS and Kentucky Medicaid staff with the assistance of consumers, family members and staff from Regional Boards. The training is provided four times per year, in two regions of the state. To assist with the development and implementation of case management training activities, a Case Management/Service Coordination Advisory Committee, composed of a faculty of case managers, supervisors, consumers, family members, and advocates, was developed in 1993. This advisory committee meets quarterly and provides vision, technical assistance, training opportunities, curriculum development, and direction for mental health case management services in Kentucky. An additional training curriculum has been developed and expanded to include advanced courses for the experienced case manager (Level II) and specialized training for case management supervisors.

Mental Health Institute
The Department hosts an annual conference called the Mental Health Institute for approximately 1,000 Regional Board providers, family members, and consumers. The Institute is a major source of continuing education for behavioral health professionals employed by the Regional Boards.

Jailer Training
During SFY03 the Department received new state funding to train staff in each of the 80 jails in the Commonwealth on suicide prevention and mental health issues. In addition, training is provided to jail staff on accessing and utilizing the Kentucky Jail Crisis Triage System.

PASRR Training
The Department sponsors PASRR certification training for staff of the Regional Boards who provide PASRR Level II evaluations for persons seeking admission to nursing facilities. The Department also sponsors PASRR skills training through a contract with the University of Kentucky Sanders-Brown Center on Aging.

Leadership Academy
The Office of Consumer Advocacy within KDMHMRS sponsors a Leadership Academy for consumers who want to develop their leadership potential. More recently a train-the-trainers event has also been added to increase capacity for this popular training.

Cultural Competency Training
The Department sponsors cultural competency "train-the-trainers" sessions twice per year for interested Regional Board and facility staff. The training uses a curriculum developed in SFY 97. Additionally, two seminars targeted for KDMHMRS central office staff are also provided on an annual basis.

Community Support Services Training
KDMHMRS staff convenes quarterly meetings of directors of Community Support Services programs and staff. These meetings and other training events are ideal settings for the provision of innovative training in evidence based practice and technical assistance from state and national experts in the areas of rehabilitation and recovery, continuity of care, housing, crisis response systems, dual diagnosis and more.

Deaf and Hard of Hearing Training
The KDMHMRS Statewide Coordinator for Deaf and Hard of Hearing Services, along with a new Program Coordinator staff member, continue to provide on-going statewide training, technical assistance and consultation regarding the provision of mental health services and communication with persons who are deaf or hard of hearing. Continued training of Deaf awareness and correct TTY usage is also provided. Additionally, training to inform and empower the deaf and hard of hearing community regarding their rights to services and how to obtain needed, appropriate services is ongoing. Accessing and using technology remains an important aspect of all contacts with providers and consumers.

Training of Emergency Services Personnel
To build on this successful initiative, KDMHMRS uses Block Grant funds to partner with NAMI Kentucky to fund a cross-systems training coordinator. This position works across multiple systems (including mental health, mental retardation, substance abuse, corrections, criminal justice training, jailers association, and Kentucky State Police) to advocate for and coordinate training modules for police officers that encounter persons with severe and persistent mental illness. This position is also developing training curriculums for other first responders including emergency medical responders and judges.

Suicide Prevention Training
As part of Kentucky's Plan to respond to the Surgeon General Call to Action to address suicide prevention, the Kentucky Suicide Prevention Planning Group was formed in 2002 and identified a model training that is being offered in several venues across the state. "Q.P.R" Question, Persuade, Refer was adopted by the group as a model training for everyone related to suicide. Certification training was provided to over 30 individuals from various areas of the community by Dr. Paul Quinett in the fall of 2003. This certification of trainers will continue in SFY 2006. In addition, KDMHRS will host a statewide Suicide Prevention Conference in September of this year.

Component 4: Financial Resources

Regional Perspective
Regional Boards have not been able to avoid the budgetary constraints that the Commonwealth has experienced. Some of the specific challenges they have been faced with include:

- A cut in state general fund dollars (2.5% in SFY 2004 and an additional cut of 2.5% in SFY 2005);
- Increased costs associated with payment of health insurance for staff;
- Increase in employer contributions towards staff retirement funds.

In addition, the state hospitals have experienced budgetary cuts and have been faced with a reduction of staff and subsequent bed capacity. The loss of private inpatient beds in communities, has also placed an increasing demand on the boards to provide less restrictive levels of services with no additional resources to manage the demand.

Although there has been an increased effort by KDMHMRS to allow for much more flexibility in planning for service over the last three years, it continues to be challenging to the boards to meet the increasing needs without substantial increases in revenue.

State Perspective
KDMHMRS does not provide direct community-based services, but assures the delivery of services through contracts with the fourteen Regional Boards.

CMHS Block Grant funds are subcontracted by the Department to the Boards based on an approved Plan and Budget. The Plan and Budget is the basis for the contractual agreement between the Department and a Regional Board to provide services that are consistent with fund source requirements, departmental priorities, service definitions and standards. Regional Boards may subcontract with appropriate community agencies to provide the contracted services.

SFY 2006 Financial Resources Summary – Adult Services

The following table summarizes the financial resources available for SFY 2005 to support the comprehensive array of adult mental health services:

SFY 2006 ALLOCATIONS	
Fund Source	**Amount**
Restricted MH General Fund & Decriminalization	$12,033,611
Flexible MH General Fund & Community Care Support	$13,512,554
CMHS Block Grant	$3,921,596
PATH	$352,000
PASRR	$1,066,900
Community Medications	$5,373,100
Personal Care Homes (MHGF)	$7,445,666
Housing	$1,016,901
Acquired Brain Injury	$2,470,662
Olmstead Wraparound	$800,000
Other Federal funds	$332,888
Medicaid	$50,520,942
Other Local	$14,956,246
Total Adult Allocations	$113,803,066
Funds allocated for services to either Adults or Children ($726,281) are not included in the above total.	

SFY 2006 CMHS Block Grant Allocations

The following table illustrates CMHS Block Grant allocations for services to adults with severe mental illness in SFY 2006 listed by the components of the array discussed in Criterion 1:

Component	Block Grant Amount
Consumer and Family Support	$733,968
Emergency Services	$219,357
Mental Health Treatment	$131,099
Specialized Mental Health Treatment	$2,558,093
Other (Training, Planning, etc.)	$344,549
Total SMI	**$3,987,066**
CMHS Block Grant Funds allocated to REGIONAL BOARDS for services to either Adults or Children ($162,445) are not included in the above total.	

SFY 2006 Funded Entities – Adult Services

The table below shows SFY 2006 CMHS Block Grant funding by funded entity.

TABLE A	
Region/Contract	**Amount of Adult CMHS Award for SFY 2006/FFY 05**
1 – Four Rivers	$136,201
2 – Pennyroyal	183,823
3 – River Valley	201,443
4 – LifeSkills	289,935
5 – Communicare	149,778
6 – Seven Counties	963,555
7 – NorthKey	288,515
8 – Comprehend	35,731
10 – Pathways	234,822
11 – Mountain	182,607
12 – Kentucky River	80,045
13 – Cumberland River	251,551
14 – ADANTA	124,853
15 – Bluegrass	430,856
KHC	13,334
Corrections	50,000
Voc Rehab	75,000
EKU	251,990
UK	23,027
TOTAL	**$3,987,066**
*Funds allocated to provide MH services For either Adults **or** Children (not included above)*	$162,445

A list of funded entities is provided on the following page. These entities will be funded with FFY2004 and FFY 03 Carryover funds consistent with priorities of the Mental Health Services Planning Council and the KCMHMRS plan and budget process.

Funded Entities

Regional MH/MR Boards

Region 1
Four Rivers MH/MR Board, Inc.
425 Broadway, Ste 201
Paducah, Kentucky 42002-7287

Region 2
Pennyroyal Regional MH/MR Board, Inc.
P O Box 614
Hopkinsville, Kentucky 42241-0614

Region 3
River Valley Behavioral Health
P O Box 1637
Owensboro, Kentucky 42302-1637

Region 4
LifeSkills, Inc.
P O Box 6499
Bowling Green, Kentucky 42101-6498

Region 5
Communicare, Inc.
107 Cranes Roost Court
Elizabethtown, Kentucky 42701

Region 6
Seven Counties Services, Inc.
101 W. Muhammad Ali Blvd.
Louisville, Kentucky 40202

Region 7

NorthKey Community Care
P O Box 2680
Covington, Kentucky 41012

Region 8
Comprehend, Inc.
611 Forest Avenue
Maysville, Kentucky 41056

Region 9/10
Pathways, Inc.
P O Box 790
Ashland, Kentucky 41100

Region 11
Region XI (Mountain Comp. Care Center)
104 South Front Ave.
Prestonsbug, Kentucky 41653

Region 12
Kentucky River Community Care
P O Box 794
Jackson, Kentucky 41339-0794

Region 13
Cumberland River Comp. Care Center
P O Box 568
Corbin, Kentucky 40702

Region 14
The ADANTA Group
259 Parkers Mill Road
Somerset, Kentucky 42501

Region 15
Bluegrass Regional MH/MR Board, Inc.
1351 Newtown Pike
Lexington, Kentucky 40515

Other Funded Entities

University of Kentucky Research Foundation
109 Kinkead Hall
Lexington, KY 40506-0057

Kentucky Dept. of Corrections
State Office Building - 5th Floor
Frankfort, KY 40601

Cabinet for Workforce Development/OVR
Capital Plaza Tower
500 Mero St.
Frankfort, Kentucky 40601

Kentucky Housing Corporation
1310 Louisville Road
Frankfort, Kentucky 40601

Eastern Kentucky University
100 Stratton Building
Richmond, Kentucky 40675

PERFORMANCE INDICATOR 1

Goal: To assure that the recovery oriented mental health system has: An adequate number of mental health professionals; A culturally competent workforce; Adequate and appropriate training of mental health professionals; and Adequate financial resources.
Target: It is anticipated that 38% of funding will support community based services.
Population: Adults with SMI
Criterion: 5
Performance Indicator: Community Service Proportion of State Mental Health Funding

Value:	Percent
Numerator:	Mental Health allocations to the Regional Boards minus the allocations for privatized state supported hospitals and personal care homes.
Denominator:	Total KDMHMRS mental health allocations to the Regional Boards and state personal care homes.

Sources of Information: Allocations as designated to each of the Regional Boards and review of their reported expenditures at year end. Not all regions have submitted their financial implementation reports in time for incorporation in this report.
Significance: This is considered a valuable indicator of the resources available to meet an ever increasing demand for services. The amount available to serve Kentucky's adults with SMI in the community is considered inadequate to meet the need.

Performance Indicator 2

Goal: To assure that the recovery oriented mental health system has: An adequate number of mental health professionals; A culturally competent workforce; Adequate and appropriate training of mental health professionals; and Adequate financial resources.
Target: A projection of $32.65 is anticipated for this indicator for 2006.
Population: Adults with SMI
Criterion: 5
Performance Indicator: Per Capita State Mental Health Expenditures

Value:	Percent
Numerator:	Annual KDMHMRS mental health dollars allocated to the Regional Boards, state hospitals, and personal care homes.
Denominator:	The Kentucky 2000 census.

Sources of Information: Allocations as designated to each of the Regional Boards and review of their reported expenditures at year end. Not all regions have submitted their financial implementation reports in time for incorporation in this report.
Significance: This is considered a valuable indicator of the resources available to meet an ever increasing demand for services. The amount available to serve Kentucky's adults with SED is below the national average.

Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

STATE ACTION PLANS

Component 1: Staffing Resources
A number of trends and challenges make recruiting and retaining a quality workforce motivated to work in CSP programs a difficult process:

- Low pay for CSP staff, compared with outpatient clinicians;
- Lower status associated with the rehabilitation field;
- Lack of a career ladder;
- Lack of specialized training opportunities that directly relate to one's job duties;
- Limited standards of care in the CSP program; and
- Limited master's level programs in rural areas.

The Department's strategies in ensuring that the workforce is well trained have been to:
- Provide inexpensive in-service training;
- Establish linkages with universities to promote pre-service and in-service training and to facilitate recruitment;
- Develop staff certification programs in the areas of case management and geriatric assessment and to offer an extensive curriculum in the basics of clinical practice; and
- Encourage the employment of a diverse and qualified work force that is culturally competent and representative of minority persons.

The Department has worked with the state Department of Personnel to identify policies and procedures that impede the recruitment and retention of qualified staff. An agreement between the Department and the state Department of Personnel allows Regional Boards to receive names and addresses of eligible persons seeking employment in mental health professions.

Several mechanisms for collecting data are becoming available to KDMHMRS in our on-going efforts to ascertain the supply and demand of human resources statewide and to improve the recruitment and retention of mental health professionals within the state. Among them are:
- HB 843 Regional Planning Council's needs assessments;
- A study prepared for the HB 843 Commission on the availability of licensed and certified behavioral health professionals in Kentucky;
- The Olmstead State Plan Committee's strategies for collecting and improving outcomes data; and
- Strategies developed at a regional "Provider Summit" meeting attended by Kentucky representatives in November, 2000.

As a result of the HB 843 process, regional needs assessments provide a basis for assessing behavioral health human resource needs across the state. The comprehensive, point-in-time count of all certified and licensed mental health professionals in Kentucky accomplished for the Commission is now available for comparison against national rates.

Representatives of Kentucky participated in a regional Provider Summit in November, 2000 to increase the availability of behavioral health professionals for states that serve the Appalachian region. The purpose of the Summit was to promote study by states of behavioral health care provider needs and to develop strategies to improve the availability of services and providers. The Health Resources and Services Administration and Substance Abuse and Mental Health Services Administration jointly sponsored the Summit, and are making on-going technical assistance available to work groups established by participating states. Meetings continue between the Department, Regional Boards, Office of Inspector General and state higher education to promote the need for additional trained personnel.

While these initiatives are still in progress, comprehensive, accurate and valuable data are being collected that will assist Kentucky in making national comparisons and in developing meaningful plans to address human resource issues in Kentucky.

- ❖ **State Objective A-5-1:** Assist regions with developing evidenced based treatment protocols for specific mental health disorders in adults.

Component 2: Cultural Competency

There is an identified need to promote greater public awareness and recognition as to the importance of ensuring that behavioral health services are provided in a culturally competent fashion. The pertains not only to sensitivity in the areas of age, gender, race, ethnicity, religion, color, national origin, disability, and sexual orientation, but also relates to work experience, personality, geographic origin and ability and skill levels.

Due to the racial composition of Kentucky's population (91% Caucasian), there is a widely held perception that the state's population is essentially homogenous, thus making cultural competency a matter of little importance. On the contrary, Kentucky's population is quite diverse in its makeup. The largest variance within this population pertains to regional differences. The western portion of the state is largely agrarian, the Louisville and Lexington areas are urban, and the eastern portion of the state has a deep-rooted Appalachian culture. In addition, a large portion of Kentucky's African American community resides in western Louisville and near the two major military bases located in this state. Another relevant factor is the growing Hispanic segment of the populace.

- Advocate for the importance of recognizing and promoting the need to have as culturally competent a behavioral health work force that is as culturally competent as possible.
- The Department should continue to take a lead role in arranging for and providing ongoing training concerning its cultural competency curriculum.

- ❖ **State Objective A-5-2:** Continue to provide and promote at least two cultural competency "Training of Trainers" sessions each year.
- ❖ **State Objective A-5-3:** Ensure that all Department sponsored cultural competency training activities are responsive to the needs of the facilities and Regional Boards and reflect best practice approaches in this field.

Component 3: Training Initiatives

A number of challenges confront the Department and Regional Boards in our effort to develop a well-trained workforce. These challenges include:

- With constant pressures to produce "billable hours", most clinicians have very little time to devote to training, especially training that is conducted out of the office;
- The cost of sending staff to training is a deterrent to most agencies with limited budgets;
- Training in evidence-based practices is difficult to sustain as it involves a comprehensive set of skills that need to be learned and practiced over time; and
- High turnover among direct service workers forces agencies to focus on basic training topics that all staff must have.

The Department's main strategy has been to sponsor a number of free or inexpensive statewide and focused regional training events through which Regional Board staff can earn Continuing Education Units (CEUs) and obtain and maintain necessary certifications or licensures. Other strategies that are being examined include:

- Providing training through the Kentucky Virtual University or other internet based learning environments;
- Coordinating the scheduling of Departmental training and technical assistance events so that Regional Board staff do not have to travel as far or as frequently;
- Posting Department sponsored training events on the web; and
- Providing on-line registration for all training events.

- ❖ **State Objective A-5-4:** Develop a Community Support Program (CSP) training plan that identifies core topics and potential presenters, for delivery during quarterly CSP meetings, the Mental Health Institute, the Case Management Conference, and other scheduled CSP training events.

Component 4: Financial Resources

The obvious challenge for the Department is to maintain existing programs while Kentucky, along with most other states, face a growing crisis in state revenues. Other challenges include:

- Maintaining a focus on serving those most in need while allowing greater fiscal flexibility at the regional level;
- Expecting the same level of outcomes from programs that have not had an increase in funding in a decade; and
- Maintaining safety net services (e.g. crisis services) at the Regional level.

Strategies used by the Department include:

- Moving toward performance based contracting (allowing greater flexibility while holding Regional Boards more accountable for outcomes);
- Moving the focus to developing effective systems of care for adults with severe mental illnesses from developing specific program interventions; and
- Developing focused biennium budget requests that are based on a strong needs assessment, in concert with the HB 843 Commission.

- ❖ **State Objective A-5-5:** Develop a biennium budget request by August 30, 2006 that reflects the priorities established by the Mental Health Services Planning Council and the HB 843 Commission and that provides significant new funding for the "safety net" services at the regional level.

Comments from Mental Health Planning Council Meeting August 18, 2005:

Comment: Council member offered corrected information regarding changed name of entity (due to state government reorganization).
Response: Staff will ensure name and address are correct for the Office of Vocational Rehabilitation.

CHILDREN WITH SEVERE EMOTIONAL DISABILITIES

Criterion 1: Comprehensive Community Based Mental Health Services System

The plan provides for the establishment of an organized, community-based system of care for children including health, mental health and rehabilitation services, employment, housing, educational, medical, dental, substance abuse treatment, support services, services provided by local school systems under IDEA, case management, and services for co-occurring (MH/SA) disorders, which enable such individuals to function outside of inpatient or residential institutions.

GOAL: To ensure that all children with severe emotional disabilities, and their families, receive the most effective services in the least restrictive environment.

INTRODUCTION

The Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) administers a comprehensive, community-based system of mental health care for children with severe emotional disabilities (SED), and their families. With guidance from the Surgeon General's Report on Children and Mental Health[1], the New Freedom Commission Report[2] and Healthy Kentuckians 2010[3], the department strives to further promote the Children's System of Care principles and objectives, while at the same time ensuring autonomy at the regional level for service planning and decision making.

Regional Mental Health/Mental Retardation Boards (Regional Boards), in conjunction with Regional Planning Councils (RPCs), which are comprised of at least 51% consumers and family members, are required to specifically describe their current children's system of care and to state their plans for development regarding four key system components. These are:

- Consumer/Family Involvement and Support
- Clinical Services
- Service Coordination
- Systems Interface

KDMHMRS is committed to working collaboratively with Regional Boards to continuously enhance continuity of care, service effectiveness and accountability. Current activities regarding each of these four components are discussed below, offering detail from a regional and state level perspective. Related goals and action plans for targeted components are discussed collectively at the end of Criterion 1.

Component 1: Consumer/Family Involvement and Support

REGIONAL PERSPECTIVE

Across all regions of Kentucky, parents' voices are most consistently heard through their membership on Local and Regional Interagency Councils. These Councils are responsible for the identification of children with SED and for coordination of the services that they receive. These representatives also make up the State Family Advisory Council (SFAC), which serves in an advisory capacity to the State Interagency Council to Children with an Emotional Disability (SIAC).

The majority of regional IMPACT programs, which serve children with SED and their families, also have

Citations:

1. U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: 2000
2. New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America Final Report*. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003
3. *Healthy Kentuckians 2010.* Kentucky Cabinet for Health and Family Services, 2001.

staff positions of "Family Liaison." These individuals provide peer-to-peer mentoring, facilitate the creation and maintenance of local parent support groups/family network activities, provide education and offer technical assistance on a variety of topics to families and service providers.

A review of the information from the SFY 2006 Annual Plan and Budget applications submitted by Regional Boards reveals that there are ongoing efforts to maintain and increase consumer/family involvement at all levels of the service system, including:

- Parents participating on Regional Planning Councils in all fourteen regions and serving on various regional and state level policy and program development committees;
- A growing number of "grandparents raising grandchildren" support efforts;
- Regions creatively building their consumer networks and providing for parent input into programming and future planning for children's programming;
- At least one parent support group is active in twelve regions and there are six support groups across the state for transition age youth;
- A parent newsletter is regularly published in eight regions;
- A resource library either dedicated for use by parents or available to parents and staff in ten regions;
- Parents acting as evaluators for several initiatives and participating in focus groups to analyze gathered data; and
- Provision of parenting skills training for parents/family members, and sponsored "family fun events" for children and families, in most regions.

STATE PERSPECTIVE

It is the belief of KDMHMRS that parents' voices should help shape not only individual treatment decisions, but also program development and policy determinations at the local, regional, and state levels. This principle is strengthened by the advocacy efforts of parents at various points in the system of care. In support of this vision, significant portions of state general funds and approximately 16 percent of the children's portion of CMHS Block Grant funds are allocated to youth consumer and parent initiatives at each level.

Opportunities for Family Leadership (OFL) is a unit within KDMHMRS which offers a resource line for parents and caregivers. The resource line connects families with the OFL program, which is a first step for accessing education, resources and support. The toll free number for the resource line is (800) 374-9146. OFL provides numerous services for families and the systems that serve them, including:

- Training in advocacy, communication, cultural competency, collaboration and legal rights in schools;
- Awarding mini-grants for parent support groups to develop local training (over 200 training events were funded in SFY 2005);
- Providing technical assistance to ensure Standards of Practice for Family Liaisons across the state are met and approving required trainings per the Standards of Practice;
- Distributing reader friendly versions of Client Rights and Grievance Procedures, and supporting documents to parents and others to ensure that these policies and procedures are understood by everyone; and
- Providing technical assistance to organizations and individuals with regard to children's mental health, mental retardation and substance abuse services and supports. Resource information and training opportunities are among the many items provided on OFL's web site at ***http://mhmr.ky.gov/mhsas/OFL.asp***

The Kentucky Partnership for Families and Children (KPFC) is a statewide organization dedicated to improving services for children with emotional, behavioral and/or mental health disabilities by providing support, education and advocacy to youth and families. There are over 1,500 members statewide.

Their Board of Directors is comprised of 30 members, with 60% being parent representatives. Activities of the KPFC include:

- Dissemination of printed information and a quarterly newsletter;
- Participation on numerous interdisciplinary committees;
- Operation of a web site (www:kypartnership.org) and a toll-free phone number (800-369-0533) for parents to access information about KPFC and resource information statewide;
- Distribution of scholarships for parents and youth to attend conferences and other advocacy events;
- Formation of a statewide Youth Council comprised of 14-25 year olds who have an emotional disability/mental illness; and
- Formation of Regional Youth Councils in partnership with Regional Boards to replicate the statewide council.

Component 2: Clinical Services

REGIONAL PERSPECTIVE

All Regional Boards have a designated Children's Services Director. These Directors, along with others, seek to ensure that the mental health service needs of children and families in their service region are assessed, addressed and evaluated in a structured, yet flexible manner. Such services are designed to address the holistic needs of children with SED, as well as those of the general population of children served in their region.

A review of the information from the SFY 2006 Annual Plan and Budget applications reveals that Regional Boards continually strive to address barriers and meet the clinical service needs of children and families. Some examples of this include:

- Twelve regions offer therapy appointments during evening hours in at least one of their office sites, and seven offer services during weekend hours;
- All regions offer walk-in appointments for children/families in crisis;
- Most regions formally include crisis planning in the treatment planning process;
- All regions offer services off-site, with all offering school-based services in the majority of counties in their region and the majority offering in-home services in most counties;
- All regions employ a designated Child Sexual Abuse Coordinator; and
- All regions employ a designated Coordinator for Early Childhood Mental Health Services and serve children of all ages, including children birth to five years of age.

The table below represents an overview of the Available Services Array for Children provided by each of the fourteen Regional Boards across the state.

Children's Array of Services: Availability by Region from Plan and Budget Application for SFY 2006

Services		Clinical Services	Psychiatry **	Early Childhood Specialist	Service Coordination	Therapeutic Child Support Services	School Based Services	Intensive In-home	After-School Program	Specialized Summer Program	Crisis Stabilization Program	Day Treatment Program	Therapeutic Foster Home(s)	Partial Hospitalization Program	Other (please specify)
Regions	1	X	X	X	X	X	X				X			X	
	2	X	X	X	X	X	X	X		X	X		X		
	3	X	X	X	X	X	X	X	X		X		X	X	
	4	X	X	X	X	X	X		X	X	X		X		
	5	X	X	X	X	X	X	X	X	X	X				
	6	X	X	X	X	X	X	X	X	X	X	X			
	7	X	X	X	X	X	X			X	X			X	
	8	X	X	X	X	X	X			X	X				
	9/ 10	X	X	X	X	X	X	X	X	X	X	X			
	11	X	X	X	X	X	X	X		X	X	X			
	12	X	X	X	X	X	X	X	X	X	X	X	X		X ***
	13	X	X	X	X	X	X		X	X	X	□	□		
	14	X	X	X	X	X	X		X	X	X	X	X		
	15	X	X	X	X	X	X	X	X	X	X		X		X ****

* At least 50% of time dedicated to services for children and families

** At least one year of specialized child training

*** Region 12 Other: Co-occurring MH/SA Services

□ Region 13 Day Tx available through the school system, in four counties

□ Region 13 Partial by the Trillium Center, in one county

**** Region 15 Family Preservation and Reunification Services

STATE PERSPECTIVE

KDMHMRS lends on-going technical support to Regional Boards to ensure quality service delivery for children and families. The majority of the Division staff within KDMHMRS is licensed mental health professionals and has previously been employed by Regional Boards or other providers of various services for children with SED. Thus, they bring first hand knowledge and perspective to their role as liaisons to the Regional Boards.

KDMHMRS is committed to "moving forward" the knowledge and skill level of clinical service providers to ensure that clients and families receive quality mental health and rehabilitative services that promote resiliency and recovery. The department strives to accomplish this by:

- Assessing current policy/philosophy and practice of the Regional Boards, as well as keeping abreast of such among other child serving agencies;
- Providing formal and informal technical assistance, training, and encouraging two-way dialogue between the department staff and Regional Boards about a full range of clinical issues; and
- Proposing and implementing policy and legislation and seeking funding to enable movement towards an optimal children's system of care. Often this is best achieved through formal and informal partnerships with other child-serving state agencies. Partnerships with colleges and universities and the business community are also considered beneficial to achieving stated goals.

Currently, the department is focusing resources on the following items to achieve its goals:

- Research-based clinical and rehabilitation practices;
- Efficacious assessment and outcomes tools;
- Diagnosis-specific treatment protocols;
- Reduction of seclusion and restraint practices;
- Client-driven treatment planning and service delivery;
- Prevention and early intervention services;
- Co-morbid health issues (obesity, suicidal ideation, abuse and neglect);
- Co-occurring disorders (mental health/substance abuse and mental health/mental retardation and developmental delays, and mental health/acquired brain injury);
- Transition services (youth to adulthood);
- Education and employment;
- Custody relinquishment for the purpose of obtaining services;
- Physical and dental health screenings and referral protocols; and
- Crisis intervention and other emergency services.

Current activities concerning several of these items are discussed below and are also addressed under *Action Plans* at the end of Criterion 1.

Early Childhood Mental Health

The President's New Freedom Commission on Mental Health recommends that states "promote the mental health of young children." This requires specialized training of clinical, administrative, and case management staff. While the Early Childhood Mental Health (ECMH) Initiative has improved both training of clinicians in the area of infant and early childhood mental health and access to these services for families of young children, there remains a general lack of knowledge in this area on the part of clinicians and administrators. Further, an objective evaluation of the program has not yet been implemented in order to track program outcomes or client improvement over time. In SFY 2003, expansion funds were allocated to each Regional Board to hire an ECMH Specialist to work with children age birth to five years that are served in early care and education (child care) settings, and their families. The primary goals of the ECMH Program are to provide:

- Program and child level consultation to early care and education (child care) programs regarding social, emotional, and behavioral issues;
- Training on working with young children with social, emotional, and behavioral needs and their families to child-serving agencies and individuals; and
- Evaluation, assessment, and therapeutic services for children age birth to five and their families.

In this year's application, a new Performance Indicator has been added to share the data that has been collected over the past two years with regard to increasing services to young children.

School-Based Mental Health

Currently, there are numerous school-based mental health initiatives across the state. Various models for school-based and off-site service provision continue to be studied and assessed for feasibility and effectiveness. KDMHMRS has sponsored several training seminars featuring national presenters to educate personnel of the Regional Boards and school districts. These have been well attended and partnerships between school districts and Regional Boards are growing statewide.

The current emphasis in the area of school-based mental health is on an integrated, multi-tiered approach that includes mental health promotion, early intervention, and intensive interventions utilizing a model of Positive Behavior Interventions and Supports (PBIS). The PBIS model encourages the involvement of mental health staff and parents at every level of intervention and support (universal/primary, targeted/secondary, and intensive/tertiary.)

For several years KDMHMRS and the Kentucky Department of Education (KDE) have been implementing parallel programs based on this model through the Bridges Project, KDE Model Schools, KIDS and Instructional Discipline Pilot Program (IDPP) initiatives. Recently KDE created the Kentucky Center for Instructional Discipline (KyCID) to provide training, technical assistance, and support to schools across the Commonwealth in implementing PBIS. Staff from the DMHMRS and KPFC serves on the KyCID steering committee to ensure that mental health and family involvement is supported at all levels of training and implementation. For additional information, please see www.kycid.org.

Kentuckians Encouraging Youth to Succeed (KEYS), Kentucky's recently funded CMHS Children's Mental Health Initiative (systems of care cooperative agreement), will continue to develop and implement PBIS in schools in north central Kentucky. KEYS will employ Student Care Teams, consisting of a Student Service/Care Coordinator, Family Liaison, and Youth and Family Interventionist who will be located in schools/districts to assist with building a continuum of prevention, early intervention, and treatment services and supports through utilization of PBIS. These teams will work collaboratively with school personnel and staff from the KyCID to establish a school wide behavior support team to develop, implement, and monitor universal (prevention) strategies and supports. To address the needs of youth at risk of developing or beginning to exhibit signs of emotional disabilities and substance use problems, Student Care Teams will partner with school personnel to form a problem solving team that will develop, implement, and monitor targeted group and individual interventions. Finally, to address the complex needs of youth with serious emotional disabilities, including those with substance use disorders, Student Care Teams will facilitate the development of school-based wraparound planning teams.

The Department is also very interested in the drafting of Kentucky's IDEA legislation and to see whether the new language in the federal legislation will be incorporated into Kentucky's law or if in fact Kentucky will maintain the language that provides for services to children with behavioral problems and diagnoses like Conduct Disorder.

Housing

Regional Boards strive to offer community based programs for children with SED that will allow them to remain in their own homes and communities, rather than in residential settings. They collaborate with the Departments for Community Based Services and Juvenile Justice to maintain children in their own homes and communities whenever possible and when in the best interest of the child. Psychiatric hospital admissions of children in the IMPACT program are tracked and reported to the Department.
KDMHMRS does not assume custody of children within the state, nor do they operate a children's psychiatric hospital or any other residential programs for children. The Regional Boards, under contract with the Department, do offer a limited amount of residential care. Therapeutic foster care is offered in six of the fourteen regions. There are also a few Boards that offer overnight respite services on a limited basis. There are ten residential crisis stabilization units for children across the state, with a total of 67 beds. The remaining four Boards offer mobile crisis stabilization services and often contract for overnight beds with a variety of providers (e.g., 23 hour acute hospital beds, private crisis stabilization residential program beds and private child care beds).

The Department for Community-Based Services (DCBS-child welfare agency), within the Cabinet for Health and Family Services, has the authority for removing children from their custodial parents in cases of abuse or neglect. The Department for Juvenile Justice (DJJ), within the Justice Cabinet, also may assume custody of children. The Department strives to collaborate with these two state agencies to ensure that the mental health needs of children are appropriately identified and addressed.
Both DCBS and DJJ contract with Regional Boards and private providers to meet the residential needs of children in their custody. The Department solicits data from the Department for Public Health to track hospital utilization of children. In calendar year 2003, there were 619 psychiatric beds available for youth aged birth to 17 years, with 8,646 admissions, and 179,561 inpatient days and an average length of stay of 20.8 days, for the year.

The Department is also working with partner agency representatives to develop an infrastructure for youth with disabilities who are transitioning to adulthood. There is a state-level "Transition Core Team" that has worked to organize existing resource information and facilitate the development of regional transition teams. There have been two statewide forums (January 6 and March 28, 2005) to enhance this "roll-out" process.

Homelessness of children is discussed in Criterion 4 of this document.

Physical Health, Dental Health and Vision Care

Regional Boards are required to conduct physical health screening with all clients served. Department staff has assisted several regions in improving tools used to assess physical health concerns and continues to encourage further assessment and integration of physical and mental health care.

According to the Centers for Disease Control, thirty-five percent of low-income children between two and five years of age in Kentucky are overweight or at risk for becoming overweight. Almost 15% of high school students are seriously overweight, and an additional 15% are heavy enough to be considered "at risk" of becoming overweight adults. Obesity among Kentuckians is epidemic and Kentucky's children are among the most obese in the nation. A statewide plan to address this epidemic has been compiled by the Department for Public Health in cooperation with Local Health Departments, state agencies including DMHSA, and other community partners. This work is supported by a grant from the Centers for Disease Control and Prevention. More information about this initiative can be found on the web site www.fitky.org. One Regional Board in the state, where obesity is quite prevalent among both its adult and child populations, has committed staff time and training funds to addressing the obesity and mental health connection in their own region and are sharing information statewide.

Kentucky Child Now! was recently awarded a Child Health Practitioner Support grant to assist pediatricians and other health professionals with identifying and providing appropriate treatment to children and youth experiencing mental health and substance abuse disorders. KDMHMRS and the Kentucky Association of Regional Mental Health and Mental Retardation Programs (KARP) are among the partners for the three year grant.

For dental care, access to low or no cost services are provided by the dental schools at the University of Louisville and University of Kentucky (in Lexington). They serve individuals in the clinics located in Lexington and Louisville and the University of Kentucky also provides mobile dental services which reach out to uninsured families in Eastern Kentucky- those who do not make enough money to pay for dental care but who make too much money to qualify for Medicaid assistance. There are four dental vans from the University of Kentucky. Several faith based organizations have provided the financial support needed to start these services and to keep them operating. In addition, some Christian groups have opened free clinics in church building, which are staffed by volunteer dentists who come to the region from all over the state for weeklong mission trips. And yet others hold dental events in Wal-Mart parking lots, handing out free samples of toothpaste, dental floss and toothbrushes to anyone who wants them. Still, case managers and clinicians that have knowledge of local resources and well-developed relationships with local providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve children in need who have no ability to pay for dental care. However, overall access is generally considered poor. The department does have representatives on several committees exploring dental services to children and how best to ensure outreach and treatment services to young children and children in the custodial care of the state. Several pieces of legislation have been introduced in the past two sessions of the Kentucky General Assembly to remove barriers to dentists' ability to provide low or no cost services but none have been enacted to date. It is anticipated that this will surface again in the 2006 full session.

All Kentucky children are required to have an eye exam by a Board Certified Optometrist before they enter school. This is in addition to the requirement for immunizations and hearing screenings. For children with vision problems, the Kentucky Lions Clubs are a great resource for assistance with screenings, exams, eye glasses, summer camps for children with visual impairments, and their financial support of VIPS. VIPS stands for Visually Impaired Preschool Services and is a non profit agency, founded in 1984 to provide early intervention to infants, toddlers, and preschoolers who are visually impaired and to provide education and support to families. While their main offices are located in Lexington and Louisville (metropolitan areas of the state), there is also an Outreach Program that serves more rural areas of the state. See http://www.vips.org/ for additional information.

Child Welfare and Legal Interface

Regional Boards give priority to clients referred by the Department for Community Based Services and the Department for Juvenile Justice. In many areas, formal and informal collaborative meetings are held to discuss program and treatment planning for shared clients. Clinicians also offer mental health consultation to the staff of these two Departments. Child welfare, juvenile justice and the Administrative Office of the Court are represented on the SIAC and all eighteen RIACs. In the past year, state agency staff from the Department for Community Based Services and the Division of Mental Health and Substance Abuse met with regional counterparts to facilitate renewed commitment to collaboration between the two at the regional and local level. The state agency staff first updated their collaboration manual, *Partnerships for Service: A Manual of Collaboration for Kentucky's Social Service and Mental Health Agencies.* Secondly, they met with regional administrators and assisted them in renewing or developing written collaborative agreements to help their staff members better understand the roles, resources and expectations of each agency and to formally commit to ongoing positive working relationships. The manual is full of information, agreed upon protocols and tools to ensure that each agency is able to most effectively and efficiently utilize local resources. For example, the Emotional

Injury Protocol developed in SFY 2005 by a workgroup which included local DCBS and Regional MH Board staff, among others, is included in the manual.

Substance Abuse Services

Substance use/abuse among children and adolescents, and their caregivers, is often identified by Regional Board clinicians as a contributing factor to the mental health and well being of clients they serve. While funding sources for substance abuse services are quite limited for youth, the use and abuse of nicotine, alcohol, inhalants, prescription and illegal drugs is addressed in the treatment provided. Clinicians and case managers utilize education (prevention and intervention), treatment and referral mechanisms available through school districts, law enforcement agencies, private providers and Regional Board Prevention programs.

Regional Boards serve youth with substance abuse disorders in their outpatient programs, as well as in the IMPACT (targeted case management) program. Several Regional Boards have specialized inpatient and intensive outpatient substance abuse programs for youth. Additional training in the treatment of co-occurring mental health and substance abuse among youth is regularly provided to case managers and clinicians at the two annually held statewide conferences, the Mental Health Institute and the Choices and Changes Conference.

The Divisions of Mental Health and Substance Abuse were officially combined by Executive Order during SFY 2004. This has and will continue to influence the manner in which Department staff thinks about and administer services for individuals with mental health and substance abuse disorders.

The Department works closely with the Kentucky Adolescent Substance Abuse Consortium. This is a group of various stakeholders committed to enhancing the quality and types of treatment services available to adolescents through collaboration, support, education, and advocacy.
For additional information see http://mhmr.ky.gov/sa/kasac.asp.

Operated within the Regional Boards' Prevention programs is the Early Intervention Program (EIP). EIP is a collaborative between DMHSA and the Office of the Governor (Governor's Title IV Drug Free Communities and Schools funds) and provides multifaceted prevention and intervention services targeting specific needs related to alcohol and other drug behavior and choices among youth and their families. It was established in 2001 and operates under the authority of Kentucky Revised Statute (KRS) 189A in accordance with Kentucky Administrative Regulation 908 KAR 1:315. Target populations include:

- Youth convicted of "Under 21/Zero Tolerance", driving with a blood-alcohol content of .02-.08. These youth are required to go through an Early Intervention Program to satisfy the requirements of their offense. There are twenty certified Early Intervention Specialists across the Commonwealth to provide theses services.
- The second target population is juveniles who are at risk of becoming involved or who already are involved with the Juvenile Justice System and youth who are identified as using or at risk for using substances.

For additional information about this program, please visit their web site at:
http://chfs.ky.gov/dph/saEIP.htm.

In October 2004, Kentucky was awarded a $9.5 million CMHS Children's Mental Health Initiative (systems of care cooperative agreement). This initiative, Kentuckians Encouraging Youth to Succeed (KEYS), will be implemented over six years to address co-occurring disorders (mental health and substance abuse) in children. While statewide implementation is an eventual goal, the project will serve youth in eight northern Kentucky counties including Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen and Pendleton. KDMHMRS will partner with NorthKey Community Care, the Regional

Board serving the area. Kentucky is one of only four applicants awarded funding through this grant program.

Recognizing the unmet needs of youth with co-occurring mental health and substance use disorders, KEYS will place an emphasis upon employing evidence-based strategies to identify and treat children in need of services. In SFY 2005, training was provided to staff within the NorthKey region to ensure that all clinicians are trained in the most effective treatment for co-occurring disorders among youth. This type of training will be offered statewide in subsequent years as part of the statewide implementation plan. As part of the readiness study conducted before the service site for the grant was determined, it was confirmed that there was at least one clinician qualified in treatment for dually diagnosed youth, in each of the counties served by NorthKey.

In August 2005, Kentucky was awarded a Substance Abuse and Mental Health Services Administration (SAMHSA) grant, which will provide $400,000 for three years to enhance the infrastructure supports for adolescent substance abuse treatment. In addition to increasing access to treatment services for young people, it will allow for the creation of a staff position dedicated to ensuring resources available for substance abuse treatment are being used in the most efficient manner possible.

Component 3: Service Coordination

REGIONAL PERSPECTIVE

In Kentucky, targeted case management services for children through the Kentucky IMPACT program are referred to as "Service Coordination" provided by "Service Coordinators." Kentucky IMPACT is a strengths-based, highly individualized, and collaborative model of case management utilizing Wraparound to address needs across life domains. These life domains include family, financial, living situations, educational/vocational, behavioral/emotional, psychological, social/recreational, health, legal, cultural and safety.

Legislation enacted in 1990 created eighteen Regional Interagency Councils (RIACs) that govern the regional IMPACT programs. Each RIAC is comprised of local representatives from the primary child serving agencies and a parent of a child with SED. A Local Resource Coordinator (LRC) serves as staff to the RIAC, and generally manages the regional IMPACT program. While Regional Boards employ the LRC, and IMPACT staff, each RIAC creates and monitors program policy and procedures and provides on-going consultation to the staff of their IMPACT program.

The regions who initially received funding for demonstration projects to address services for transitioning from child to adult services and several additional regions have developed services that are addressing the needs of transitioning youth. These include:

- Peer support groups for adolescents;
- Independent Living Skills training for 14-21 year olds;
- Vocational planning workshops;
- Life mapping workshops; and
- Consultation with adult case managers to ensure the smooth transition to needed services for youth reaching age eighteen or 21.

Each RIAC serves as the gatekeeper for children entering and exiting IMPACT services. Each RIAC receives an annual per capita allocation from KDMHMRS for Service Coordination, RIAC staff support, and resource development. In consultation with its corresponding Regional Board, each RIAC determines how the funds will be obligated for the support of service delivery. Eligibility criteria for acceptance of a child into IMPACT are not determined by insurance coverage or a family's ability to pay.

Flexible funds, set aside by RIACs, may be used to purchase needed goods and services when there is no other available resource. Common expenditures may include tutoring services, summer camp fees, or therapeutic interventions provided to children by trained professional or paraprofessional mentoring staff. Regional Boards act as the fiscal agents for the funds but, again, decision-making authority regarding the use of these funds rests with each RIAC.

There are currently 238 Service Coordinators statewide and IMPACT has served 23,152 children from its inception through the end of SFY 2005. During SFY 2005, 6,528 children were served (up 9% from last year) and projections are to serve an increased number, albeit small, in 2006.

While having an SED diagnosis is a part of the IMPACT program's eligibility criteria, many IMPACT clients also have the following characteristics:

- Co-occurring Mental Health/Mental Retardation diagnoses;
- Co-occurring Mental Health/Substance Abuse diagnoses;
- Pervasive Developmental Disorders, including Autism;
- Living in poverty;
- Living in Foster Care/Treatment Foster Care;
- Transitioning to Adulthood; and
- Homelessness or unstable living environments.

STATE PERSPECTIVE

KDMHMRS provides technical assistance to Local Resource Coordinators that manage the IMPACT programs by assisting with quarterly peer group meetings. Department staff also offers ongoing technical assistance and consultation to RIACs, LRCs, Service Coordinators and others as requested.

Both KDMHMRS and Kentucky Medicaid help to ensure the integrity of IMPACT's Service Coordination program standards by:

- Requiring Service Coordinators to complete certification training conducted by KDMHMRS within six months of their employment;
- Imposing caseload size restrictions;
- Prohibiting Service Coordinators from providing billable services other than Case Management;
- Requiring Service Coordinators to have a minimum of four client-related contacts per month, two of which must be face-to-face contacts with the child and his/her family, for a reimbursable service; and
- Defining what does and does not constitute an appropriate case management activity.

A ten-year evaluation report completed in September 2001 confirms the efficacy of the IMPACT program and the program has been noted nationally as a model for client/family-driven and strengths based service delivery. From its inception, there has been an IMPACT evaluation system in place. The Department has encountered several obstacles in its efforts to overhaul the evaluation system into an IMPACT Outcomes system and anticipates that this work will come to fruition in SFY 2006. This is discussed in greater detail in Criterion 2.

Component 4: Systems Interface

REGIONAL PERSPECTIVE

The Regional and Local Interagency Councils represent legislatively mandated partnerships among child serving agencies/parent partners for the purpose of planning and service delivery for children with SED, and their families, but many additional collaborative relationships exist across the state. Many regions provide clinical and consultative services as a result of formal and informal arrangements (verbal agreements, signed Memoranda of Agreement, formal service contracts with in-kind and financial resource sharing). These include partnerships between Regional Boards and local school

districts, local child welfare agencies, local health departments and other health providers, early care and education programs, Head Start providers, Child Advocacy Centers (for child sexual abuse victims), juvenile justice, law enforcement, courts and numerous others.

Due to the Regional Boards serving multiple counties, both urban and rural, regional child planners also focus efforts on ensuring continuity of care within their own systems. This includes enhanced collaboration between traditionally separate service systems (e.g., mental health and substance abuse, child and adult services for transitioning age youth, prevention and treatment), as well as between treatment providers and others within their organizations responsible for data collection/entry and quality assurance.

STATE PERSPECTIVE

The SIAC is discussed in greater detail in Criterion 3 and serves as a model for collaboration at the state level. There have been many additional ad hoc and sustained multi-partner groups that have existed over the past several years as issues arose that indicated a need for short or long term collaboration. Such work groups have included: Co-occurring disorders and Brain Injury; Clinical Pathways for Children with Autism, IMPACT Outcomes Measurement System for Kentucky IMPACT, and Protocols for Emotional Injury.

One partnership that exemplifies a formal, sustained partnership is **IMPACT Plus**. Kentucky implemented IMPACT Plus, a behavioral health program for Medicaid eligible children with complex behavioral healthcare needs, in January 1998, to increase the variety and availability of community-based service options and to decrease the need for inpatient care.

Through IMPACT Plus, Kentucky Medicaid reimburses KDMHMRS and the Department for Community Based Services (DCBS) for Medicaid billable services they purchase. KDMHMRS and DCBS in turn sub-contract with mental health agencies and private mental health professionals across the state to provide a wide network of traditional and innovative behavioral health services.

IMPACT Plus services expand on the Kentucky IMPACT program and traditional Medicaid services to include the following comprehensive array:

- Targeted Case Management;
- Outpatient Services (individual, group, and collateral);
- Therapeutic Child Support Services (behavior modification, mentoring);
- Parent to Parent Support Services;
- Partial Hospitalization;
- Intensive Outpatient Services;
- Mental Health Day Treatment;
- After School and Summer Programs;
- Residential Crisis Stabilization;
- Therapeutic Group Residential Care; and
- Therapeutic Foster Care.

A basic premise of IMPACT Plus is that cost savings realized from decreased rates of hospitalization and other restrictive levels of care would be redirected to support community-based service provision. Management staff from the participating departments continues to monitor program expenditures and adherence to this “cost neutrality” principle. Currently, identified needs include a continued focus on program reviews and utilization trends using best practice standards for each service component. Priorities include increased focus on evidenced best practice research, provider training, network capacity, and outcome measurement.

Transition (Youth to Adult) Services

The Department is currently represented on the statewide Kentucky Transition Council for Persons with Disabilities and a subcommittee, the Kentucky Transition Core Team, to address the issue of youth with disabilities who are transitioning to adulthood. The overall mission of the Core Team is to collaborate with key stakeholders to develop a formalized infrastructure through which students, parents and professionals can:

- Communicate and build local teams;
- Identify current practices and areas in need of improvement;
- Share resources, knowledge and unique experiences and expertise; and
- Benefit from successful outcomes and shared rewards.

The steering committee is comprised of representatives for several state agencies including:

- Kentucky Department of Education (KDE)/ Division of Exceptional Children Service
- KDE/ Division of Career and Technical Education
- KDE/ Special Education Cooperative Network
- Commission for Children with Special Health Care Needs
- Kentucky Office of Vocational Rehabilitation
- Kentucky Deaf Blind Project
- Interdisciplinary Human Development Institute (University of Kentucky)
- Kentucky Department for Mental Health and Mental Retardation Services

There were two statewide Forums held in 2005 to develop regional teams to address the resources and service gaps for transitioning aged youth and their families. This work is expected to continue in 2006 and core team members will be available to assist regional teams as they establish themselves and determine short and long term goals. Primary funding for this initiative to date has come from KDE as they have designated successful secondary transition as a key issue to address in their State Improvement Grant from the Office of Special Education Programs (OSEP).

PERFORMANCE INDICATOR

Goal: To ensure that all children with severe emotional disabilities, and their families, receive the most effective services in the least restrictive environment.
Target: Increase access to targeted case management provided by Regional Boards by at least .2%
Population: Children with SED
Criterion: 1
Performance Indicator: Penetration Rate--Children with Severe Emotional Disabilities Receiving Targeted Case Management

Value:	Percent
Numerator:	Unduplicated sum of children served during the SFY with an SED marker in the KDMHMRS data set who received a Regional MHMR Board Targeted Case Management service.
Denominator:	Five percent of the 2000 Kentucky child census.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 118, 122 &123) and knowledge of various factors that may impact the system.
Significance: This is considered a valuable indicator of the population served and it is representative of the increase in demand for services on a system that has experienced little more than flat line funding for a number of years. It may also represent improvement in appropriate use of the SED marker in the MIS.

PERFORMANCE INDICATOR 2a

Goal: To ensure that all children with severe emotional disabilities, and their families, receive the most effective services in the least restrictive environment.
Target: Ensure that at least 43% of the Regional Boards will provide Therapeutic Foster Care
Population: Children with SED
Criterion: 1
Performance Indicator: Evidence-Based Practices-Provision of Therapeutic Foster Care by Regional Boards

Value:	Percent
Numerator:	Number of EBPs (therapeutic foster care programs) for Children with SED provided by Regional Boards.
Denominator:	Number of EBPs for children with SED potentially available from Regional Boards (i.e., total number of Regional Boards)

Sources of Information: Report of Therapeutic Foster Care programs offered by Regional Boards as reported in the corresponding year's Plan and Budget applications from the Boards.
Significance: There are six Boards that offer this evidence-based practice considered a preferable setting for meeting the needs of children with SED when they are not able to live in their own family home.

PERFORMANCE INDICATOR 2b

Goal: To ensure that all children with severe emotional disabilities, and their families, receive the most effective services in the least restrictive environment.
Target: Ensure that at least 1.3% of the total number of children with SED served by the Regional Boards receive Therapeutic Foster Care, from a Regional Board provider.
Population: Children with SED
Criterion: 1
Performance Indicator: Evidence-based practices-Number of Children with SED receiving Therapeutic Foster Care service.

Value:	Percent
Numerator:	Number of Children with SED who receive therapeutic foster care services provided by Regional Boards.
Denominator:	Number of children with SED served by the Regional Boards.

Sources of Information: MIS data collected on the provision of therapeutic foster care- event code 27 in the MIS.
Significance: There are six Boards that offer this evidence-based practice considered a preferable setting for meeting the needs of children with SED when they are not able to live in their own family home. The majority of children receiving therapeutic foster care in Kentucky are served by private providers other than Regional Boards.

PERFORMANCE INDICATOR 3

Goal: To ensure that all children with severe emotional disabilities, and their families, receive the most effective services in the least restrictive environment.
Target: Ensure that at least 48% of the total number of children with SED served by the Regional Boards report positive responses on the consumer satisfaction instrument.

Population: Children with SED
Criterion: 1
Performance Indicator: Consumer Perception of Care

Value:	Percent
Numerator:	Number of Children with SED who report positive responses on the consumer satisfaction instrument.
Denominator:	Total number of responses on the consumer satisfaction instrument.

Sources of Information: Historical data is limited to a study of consumer satisfaction with services for children conducted in 2000. Future collection of this indicator is to be determined within this fiscal year. It is anticipated that the information will be collected from the Regional Boards using a standardized tool.
Significance: The perception of care as reported by consumers of services is a valuable piece of data to ensure that services are meeting the needs of those served.

Please see **Appendix A** for completed reporting tables of the Performance Indicators in the requested format.

ACTION PLANS
Serving more children with SED with the same or less financial resources can only be realized through deliberate and appropriate collaboration among all the partners in the lives of Kentucky's children.
With regard to the component of ***Family Involvement and Support***, several efforts will continue in SFY 2006. Over the past several years, there has been an identified need for Standards of Practice for Family Liaisons. These were drafted by the State Family Advisory Council, with input from a variety of stakeholders including the Regional Boards that employ the Family Liaisons and the State Interagency Council. These standards were adopted by the SIAC and shared statewide.

There is also a workgroup that has given considerable effort to drafting a framework for a Family Involvement Outcomes Measurement System across the state. It is applicable to mental health, mental retardation and substance abuse service systems for children.

Further piloting, and expansion of specific ones to be used, is underway for the Family Involvement Outcomes Measurement System. There is also great need to offer training and technical assistance to the field but resources are limited. There are potential lessons to be learned and further revisions to the draft document to be completed. With budget constraints and multiple priorities competing for equal attention, it is sometimes a struggle to keep stakeholders at all levels engaged in furthering the Family Involvement initiatives. As time and resources become available, the drafted outcomes measurements will be implemented in different regions of the state and the results analyzed to further develop the instruments and complete the project.

- **State Objective C-1-1:** Utilize Opportunities for Family Leadership to support and promote the Family Involvement Outcomes Project and develop a plan for further expansion.

With regard to the component of ***Clinical Services***, KDMHMRS, along with its partner agencies continues to pursue expansion or increased effectiveness of successful "model" programs, including the Crisis Stabilization Network, the Community Medications Support Program, services for children birth to five years and outpatient services delivered in the community (e.g. client homes, schools, child care facilities, etc.).

The child service system is relatively well-developed and most services are available in all counties of the state or at least within a thirty-mile radius, still there are many areas where improvements are desired. The major priorities for the coming year include:

- Developing further the crisis response and utilization of crisis stabilization services to avoid hospitalization and other residential treatment services;
- Increasing the number of adequately trained and experienced clinicians/consultants to address mental health concerns for very young children (age birth to five years);
- Increasing the number of school-based services available to children;
- Collaborating with the Kentucky Transition Council for Persons with Disabilities and its partner agencies;
- Collaborating with partner agencies to share data for collaborative planning;
- Strengthening and seeking additional Memoranda of Agreement with the Department for Public Health, the Kentucky Department of Education and others to enhance utilization of limited resources; and
- Continuing the exchange of information and ideas between the department and the Regional Boards on a variety of issues.

Recommendation 4.2 of the President's New Freedom Commission on Mental Health calls for improving and expanding school mental health programs. This recommendation is mirrored across Kentucky. While all fourteen Regional Boards are implementing some level of school-based mental health services, educators and clinical staff alike still express a desire for growth in this area. In many school districts the availability of mental health professionals is insufficient to meet the need.

All of the Early Childhood Mental Health (ECHMH) Specialists have received training in working with the birth to five population, including the Infancy and Early Childhood Training Course offered annually by Dr. Stanley Greenspan. The Specialists and other Regional Board clinicians received extensive training in early childhood development and mental health from staff of the Comprehensive Assessment and Training Services (CATS) Project at the University of Kentucky. It is hoped that through this and other collaborative training efforts, the capacity for regional clinicians to serve children birth to 5 and their families continue to improve. Additionally, the Specialists provided and arranged for over 300 regional training opportunities focused on ECMH issues.

More training in the area of ECMH was identified by many of the Regional Boards in their SFY 06 Plan and Budget applications. In some regions of the state, particularly those in urban areas and those covering a large geographic are, having only one position dedicated to implementing this initiative has been difficult. Increasing the skill level of other Regional Board staff in working with this population would decrease the clinical demands on the Specialists, allowing them to spend more time providing consultation and education services to early care and education programs.

The ECMH initiative will continue to offer Regional Board staff opportunities to receive training in ECMH through their regional ECMH Specialist, as well as through the training provided by the CATS clinic staff. This will be provided through the contract between the CATS clinic and the Department for Public Health. The ECMH Specialists send a monthly report to the DPH ECMH Program Administrator. Additionally the DMH and DPH ECMH Program Administrators query the KDMHMRS client and event data sets on a monthly basis in order to track children served by the program.

The three regions which initially received funding for demonstration projects to address services for transitioning from child to adult services and several additional regions have developed services that are addressing the needs of transitioning youth. These include:
- Peer support groups for adolescents;
- Independent Living Skills training for 14-21 year olds;
- Vocational planning workshops;
- Life mapping workshops; and
- Consulting with adult case managers to ensure the smooth transition to needed services for youth reaching age eighteen.

Through participation in national, multi-site evaluation activities, Kentucky has and will continue to expand upon the research base regarding children with SED and system of care outcomes it has accumulated over the past thirteen years.

- **State Objective C-1-2:** Share relevant research-based practice literature with Regional Boards to assist them in determining effective service delivery methods for use in their child and family programs.
- **State Objective C-1-3:** Share regional information collected during the 2006 Annual Plan and Budget Application process with regional children's planners to allow them to pool knowledge and resources.
- **State Objective C-1-4:** Assist Regional Boards in implementing crisis stabilization programs through statewide technical assistance meetings to be held a minimum of three times per year.
- **State Objective C-1-5:** Assist Regional Boards in implementing therapeutic foster care programs through statewide technical assistance meetings to be held a minimum of two times per year.
- **State Objective C-1-6:** Provide statewide training and technical assistance to Regional Board staff and local education authorities in implementing components of the three-tiered, strengths-based model, including Wraparound to address mental health needs of children in school settings.

With regard to the component of ***Service Coordination***, there has long been a desire to balance regional autonomy with fidelity to true Wraparound in the Kentucky IMPACT Program. Efforts continue to ensure that program staff and all the stakeholder groups come together on a regular basis to share information about the most current research literature, lessons learned from practice, and optimal resource utilization.

Addressing workforce issues and flat lined/decreased funding faced by the IMPACT programs statewide is also a priority. Although Service Coordination is highly-valued by consumers, the position of Service Coordinator is generally considered entry level and thus is low paying, albeit a very demanding job. Individuals in these positions often move into other positions leaving the Regional Boards to struggle with recruitment and retention for the positions and with the constant need to train and support these individuals.

There is a department-wide work group that has examined the function of case management and the roles of its providers across service delivery arenas. These include case management services in mental health (adult and child), mental retardation, brain injury, and substance abuse. Guiding principles were established and, in 2006, more focus will be placed on developing Standards of Practice. The research literature indicates that targeted case management services for children and families, utilizing Wraparound and individualized service plans developed by a team including parents as expert participants, lead to optimal outcomes. Flexible funding is a desirable component of the service model and more is needed to meaningfully increase capacity in Kentucky.

Plans are underway to revise the IMPACT evaluation system to a comprehensive outcomes system that can be used at the local level to assist staff with treatment and program planning. The first step of developing child and family outcomes, identifying indicators and adoption of measurement tools, has been completed. Eventually, there is a desire to develop program and system level outcomes and indicators.

With regard to the component of ***Systems Interface***, the department serves as a leader among child serving agencies to encourage and support shared vision and collaborative planning. While the IMPACT program is considered highly successful in serving the population of children with SED in Kentucky, there is a need to refine efforts to interface with all the child serving agencies in meaningful ways. This includes making sure consumers and families are involved at all levels. It further demands utilizing local lessons learned and studying new techniques to make continued improvements in the sharing of knowledge, philosophies and resources among the agencies.

Bridges utilizes a three-tiered service model of intervention (universal, targeted, and intensive) in the schools. This is the same model used by the Kentucky Center for School Safety and the Kentucky Department of Education in schools participating in the Kentucky Instructional Discipline and Support (KIDS) Initiative. At the state level, these agencies, as well as the Department for Juvenile Justice, the Office of Family Resource and Youth Service Centers, and the Department for Public Health all support the use of this multi-tiered, comprehensive, and integrated model of service delivery.

- **State Objective C-1-7:** Develop Case Management Standards of Care in collaboration with KDMHMRS, SIAC partners, Regional Boards, and youth/families.
- **State Objective C-1-8:** Share aggregated KDMHMRS client and event data with partner agencies in an effort to enhance collaborative planning and to maximize limited resources.

Comments from the Mental Health Planning Council meeting on August 18, 2005:
There were no comments for this Criterion.

Criterion 2: Children's Mental Health System Data Epidemiology

The plan reports an estimate of incidence and prevalence of SED among children and provides for quantitative service targets to be achieved through the implementation of the mental health system of care as described in Criterion 1.

GOAL: To increase access to services for children with severe emotional disabilities.

INTRODUCTION

Using 2000 census data and the state's agreed upon prevalence rate estimate of five percent, Regional Boards are aware of the number of children in potential need of services. However, they rely more heavily on indicators and recommendations from the local communities, parent networks and Regional Planning Councils. *Kentucky Kids Count,* the annual report distributed by Kentucky Youth Advocates is also helpful for program planning. (Contact site is www.kyyouth.org.)

The chart below displays the child population for each region and the estimated number of children with SED with percentages served.

Regional MH/MR Boards	Child Census 2000	Estimated Number of Children with SED (5%)	Kentucky SED Children Served SFY 2004	Penetration Rate
Four Rivers	45,789	2,289	929	41%
Pennyroyal	51,354	2,568	578	23%
River Valley	52,376	2,619	1,163	44%
Lifeskills	62,142	3,107	1,533	49 %
Communicare	65,398	3,270	1,176	36%
Seven Counties	215,082	10,755	3,765	35%
NorthKey	105,280	5,264	896	17%
Comprehend	13,777	689	250	36%
Pathways	49,290	2,465	657	27%
Mountain	39,056	1,953	842	43%
Kentucky River	29,455	1,473	509	35%
Cumberland River	60,398	3,020	2,834	94%
Adanta	46,300	2,315	2,145	93%
Bluegrass	159,121	7,956	1,830	23%
TOTAL	**994,818**	**49,743**	**19,114**	**38%**

REGIONAL PERSPECTIVE

Based on the wide variation of regional penetration rates as charted above, it is suspected that the SED marker in the KDMHMRS data set is not consistently applied. Accuracy in coding is addressed during the Department's on-site monitoring of Regional Boards, and statistical indicators that rely on the number of children with an SED marker are increasingly used to assess performance and outcomes. Thus, Regional Boards and the Department are increasingly interested in the consistent and accurate use of the marker in the data sets.

A Regional Interagency Council (RIAC) also identifies a child as having a severe emotional disability when admitted to the Kentucky IMPACT program. In addition to taking into account the diagnosis, duration, and severity of the child's disability, RIACs also consider local priorities for service, service availability, and the child's appropriateness for IMPACT services.

In Kentucky, criteria for determining whether a child has a severe emotional disability were included in the enabling legislation (KRS 200.503) for the Kentucky IMPACT program in 1990. These criteria include the following. A child who:

1) Is under age 18 or under age 21 and was receiving mental health services prior to age 18 and the services must be continued for therapeutic benefit; and
2) Has a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; and presents substantial limitations which have persisted for at least one year, or are judged by a mental health professional to be at high risk of continuing for one year without professional intervention in at least two of these five areas:
    - Self Care
    - Interpersonal Relationships
    - Family Life
    - Self-Direction
    - Education

or

- Is a Kentucky resident and is receiving residential treatment for an emotional disability through the interstate compact; or
- Has been removed from the home by the Department for Community Based Services (Kentucky's child welfare agency) and has been unable to be maintained in a stable setting due to a behavioral or emotional disability.

Using the eligibility criteria as defined above, a child served by one of Kentucky's Regional Boards may be identified as having a severe emotional disability by the clinician who serves the child based on a combination of the child's diagnosis and the duration and severity of the child's disability. Regional Board staff places a marker in the child's file and transmits it to the KDMHMRS data system. This process accounts for the majority of children in Kentucky who are identified by KDMHMRS as having a severe emotional disability.

STATE PERSPECTIVE

Kentucky mental health planners have historically used a five percent prevalence rate estimate for severe emotional disabilities among Kentucky children. Using this rate with 2000 census data, there are approximately 50,000 children with a severe emotional disability among Kentucky's 995,000 children.

Kentucky's estimated prevalence rate falls in the low range of estimates derived from local studies and cited in "Prevalence of Serious Emotional Disturbance in Children and Adolescence" (Friedman et. al, SAMHSA, 1996). This study acknowledges the lack of epidemiological data and concludes that regardless of the estimated prevalence rate that may be used, children with severe emotional disabilities are greatly under-served, a conclusion Kentucky planners share.

When a child is identified through either process, a marker is placed in the KDMHMRS data system that identifies the child as having a severe emotional disability. Data concerning services received by children with a marker may then be compiled and analyzed.

KDMHMRS contracts with the Research and Data Management Center (RDMC) at the University of Kentucky to manage the bulk of data it collects. Their data elements include a client demographic data set, a service event data set and a human resources data set. There is also an Adult Outcomes data set that is being established.

Historically, the IMPACT evaluation system has been housed within the Children and Youth Services Branch of the Division of Mental Health and was not linked with the above-mentioned system. The PC-based systems, developed in 1990, to support the processing and interpretation of Kentucky IMPACT data have proven durable and useful over time. However, as the program has grown in size and there is greater need for integrating and sharing data with regional providers and decision-makers, the goal is to move this evaluation/outcomes system into the larger RMDC managed system. These changes are being made in coordination with the major changes underway for the Department's overall management information system.

PERFORMANCE INDICATOR 1

Goal: To increase access to services for children with severe emotional disabilities.
Target: Increase access to services provided by Regional Boards by at least .6% over the SFY 2004 actual number served.
Population: Children with SED
Criterion: 2
Performance Indicator: Penetration Rate--Children with Severe Emotional Disabilities

Value:	Percent
Numerator:	Unduplicated sum of children served during the SFY with an SED marker in the KDMHMRS data set who received a Regional MHMR Board service.
Denominator:	Five percent of the 2000 Kentucky child census.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 118, 122 &123) and knowledge of various factors that may impact the system.
Significance: This is considered a valuable indicator of the population served and it is representative of the steady increase in demand for services on a system that has experienced little more than flat line funding for a number of years. It may also represent improvement in appropriate use of the SED marker in the MIS.
Please see **Appendix A** for completed reporting tables of the Performance Indicators in the requested format.

ACTION PLANS

Regional Boards have developed various services to meet the needs of the community and individual children and families that they serve. Many outpatient offices offer services during late afternoon and evening hours. This will keep children who may already be struggling in school from missing instruction in order to receive therapy services. Many clinicians also provide off-site therapy to eliminate barriers such as transportation, childcare for siblings, missed work by parents, etc. Regional Board clinicians also offer more services at school, in after school daycare centers, homes, or in other community settings.

Planners believe that offering such flexibility in service provision results in a greater number of children and youth receiving needed services. This also moves us toward the goal of reaching children before problems are exacerbated or escalate to crisis. A continual challenge is the funding of services off-site. The additional costs associated with travel and off-site logistics are sometimes problematic.

Plans are underway to totally revise the current Kentucky IMPACT data collection and evaluation system to a IMPACT Outcomes system. A state level steering committee comprised of SIAC and Division staff as well as field staff is working closely with the University of Kentucky to devise the new system utilizing hand held personal data assistants (PDAs). The goals of this project are to:

- Evaluate the type of data needed to measure the program's effectiveness considering child and family indicators/outcomes; and
- Identify how best to manage the data so that it can be returned in a timely manner to the regional staff (Service Coordinators and IMPACT program managers) for treatment planning. It is also anticipated that aggregate data will be valuable to those making regional and state level policies that are responsive to programmatic trends.

As noted in Criterion 1, Regional Interagency Councils may approve the use of flexible, discretionary funds (wraparound expense) for IMPACT clients when there is no other payer source. KDMHMRS continues to process Wraparound Expense data, detailing expenses by service category. This information is submitted quarterly by the Regional Boards to KDMHMRS. With the exception of one region, expense data are submitted via hard copy to KDMHMRS for processing, a time consuming and potentially error-prone process for regional and KDMHMRS staff. Although it will take some time to accomplish, it is desirable to create the ability for all regional programs to electronically submit this information.

- **State Objective C-2-1:** Ensure that children with SED are accurately reflected in the KDMHMRS data system through continued analysis of the data received, technical assistance to Regional Board staff, and on-site monitoring.
- **State Objective C-2-2**: Develop a plan for implementing the newly revised Kentucky IMPACT Outcomes Measurement System.

Comments from the Mental Health Planning Council meeting on August 18, 2005:

Comment: The Planning Council noted that there has been a steady increase in all services to children with SED although funding has remained flat or reduced in some areas.
Response: Department staff concurred.

Criterion 3: Integrated Children's Services

A statewide system of integrated services will be provided so children with severe emotional disabilities (SED) will receive care appropriate to their multiple needs. Ongoing efforts are targeted at integration of social services, educational services (including services provided under the Individuals with Disabilities Education Act), juvenile justice services, substance abuse services, and health and mental health services. Defined geographic areas for the provision of the services of such a system are established.

GOAL: To ensure that services for children with severe emotional disabilities are fully integrated and holistic.

INTRODUCTION

An integrated service system for the children and families served by Regional Boards is stronger in some areas of the state than in others. Examples of truly integrated services are sometimes found in very small communities where professionals and community members are well acquainted and have a long history of working together to achieve commonly held goals for their service recipients. Often where resources are the scarcest, creativity is strongest. Larger communities, while generally having the advantage of more resources, may face greater challenges in coordinating their efforts. Human Services Council meetings in many urban and rural counties serve as a monthly opportunity to share agency information and exchange referrals. In addition, there are numerous other networking and case conferencing mechanisms in place at the local level to encourage and support general agency and client specific information exchange and collaborative planning.

Partners learning the details of each others' specific job roles and their designated service areas is generally a beneficial starting place for assuring that children and families are served in the most effective and least restrictive manner. Most agencies do have specified service areas but adjustments are sometimes made to accommodate special circumstances. Child welfare and community mental health have very similar service areas but the courts/ juvenile justice and special education cooperatives are quite different from the community mental health region configurations.

REGIONAL PERSPECTIVE

The interagency structure of Kentucky IMPACT drills down to the level of the child's service team. When a child is admitted to Kentucky IMPACT, a Service Coordinator is assigned to convene an interagency service team. The team consists of the child (when appropriate), his parent(s), his teacher(s), and other involved parties who work with the child and his family. A Regional Board is also the substance abuse and mental retardation planning authority for its region, so those services may be accessed by the Regional Interagency Councils (RIAC) through the Board's representation on the RIAC.

The Service Coordinator facilitates the team meeting in developing an interagency service plan that focuses the efforts of each member of the team on the desired outcomes for the child. The plan does not replace educational or treatment plans, including plans for educational services under IDEA, but coordinates and focuses them. The plan also identifies areas where Wraparound services may be utilized to fill service gaps.

A Local Resource Coordinator (LRC) supports each RIAC, often supervises a team of Service Coordinators, and develops local resources that can be accessed by service teams for children with SED, and their families. KDMHMRS and Kentucky Medicaid reimbursements for Targeted Case Management services help fund these staff positions. Criterion 1 and 2 provide considerable information about the delivery of Service Coordination and Wraparound, the primary services of Kentucky IMPACT.

Training in the difficult role of facilitator is provided to Service Coordinators through certification training, which is conducted by interagency trainers. The training is reinforced and supplemented through workshops and peer meetings at statewide collaborative conferences for IMPACT staff and RIAC members.

Twelve of fourteen regions report that Service Coordination services are offered to youth transitioning into adulthood, many of whom are linked with mental health services, as well as other independent living related services. Several regions also offered specialized services for this population (e.g., independent living skills training, peer support opportunities).

STATE PERSPECTIVE

In Kentucky, the system of care for children, including those with severe emotional disabilities strives to provide services utilizing Wraparound. This strategy relies on a foundation of policy makers and service providers that take into account all of the goals and day to day activities of the child when assessing the needs of the child and his or her family.

KDMHMRS continues to promote activities that build the infrastructure for coordinated and optimally integrated services for children with SED, and their families. Model examples of collaborative efforts found in the regions are often shared with others through technical assistance by the department. As discussed in Criterion 1, the State Interagency Council for Services to Children with an Emotional Disability (SIAC) is a group of representatives, from the primary child-serving agencies, and a parent of a child with an emotional disability, who maintain and oversee a framework of collaborative services for children with emotional disabilities. The hallmark program of this framework is Kentucky IMPACT, but other programs and initiatives may also fall under their auspices. The table below illustrates the composition of the SIAC and RIACs. Some RIACs have also developed Local Interagency Councils (LIACs) at the county level to mirror the composition of the SIAC and RIACs, but to enhance the ability to develop resources at the local level and to problem solve when systemic issues may arise. The Chair of SIAC alternates each year but the Chair for RIACs is legislatively mandated as the DCBS representative.

Composition of IMPACT Interagency Councils

SIAC Representative	Domain	RIAC Representative
Parent of a child with a severe emotional disability	Family Members	Parent of a child with a severe emotional disability
Commissioner, KDMHMRS	Mental Health	Director of Children's Services, Regional MH/MR Board
Commissioner, Department for Community-Based Services	Child Welfare	Service Region Administrator, Department for Community-Based Services
Commissioner, Department of Public Health	Public Health	Representative, County Health Department
Commissioner, Department for Medicaid Services	Medicaid	Not represented
Commissioner, Department for Juvenile Justice	Juvenile Justice	Regional Program Manager Department for Juvenile Justice
Executive Director, Dependent Children's Services within Administrative Office of the Courts	Courts	Court Designated Worker selected by local district judges
Executive Director, Family Resource and Youth Services Centers	Prevention and Early Intervention	Not currently required but may be added at the discretion of the RIAC
Commissioner's Designee, Department of Education	Education	Special Education Specialist, Local Education Authority

With a charge from the SIAC, a **Traumatic/Acquired Brain Injury Workgroup** has met regularly to study service delivery and supports for community living issues involved for children and transitioning youth with dual or multiple diagnoses of mental health, mental retardation, and traumatic brain injury. Representatives from several child and adult serving agencies participate as stakeholders on this group. With a similar charge from SIAC, the **Co-Occurring Workgroup** has been convened to focus on children within the Juvenile Justice system who are deemed in need of mental health and substance abuse assessment and treatment.

The Autism Spectrum Disorder Advisory Consortium (ASDAC), formed in March 2002 with representatives from the KDMHMRS, Regional Boards, KDE, the Kentucky Autism Training Center (Department of Education/University of Louisville), DCBS, and parents of children with Autism. Originally there was a workgroup that developed a "Clinical Pathways for Children with Autism" document intended to be a description of how families can access appropriate evaluations and services available in Kentucky through universities, health care providers and educational services. The Consortium continues to serve as an expert advisory body regarding services and supports to children with Autism Spectrum Disorder and their families in Kentucky.

Public Health
Staff from the Department for Public Health and KDMHMRS meets regularly as they share oversight of the Early Childhood Mental Health Initiative and the designated Specialists. There is also shared oversight of the Bioterrorism Preparedness program. Most recently, the sharing of aggregated data between the two departments has occurred and there are plans to continue these efforts in various ways, including the sharing of hospital data previously unavailable to mental health.

Education
KDMHMRS staff collaborates extensively with state and local educational agencies in support of IDEA and other initiatives focused on simplifying access to and coordinating services for children and youth with emotional and behavioral needs. Another initiative involves the department's technical assistance to the Kentucky Department of Education (KDE) to integrate a mental health and family component in the implementation of their Instructional Discipline Pilot Program (IDPP). This program is based on a three-tiered prevention model, using Positive Behavior Interventions and Supports (PBIS). The PBIS model encourages the involvement of mental health staff and parents at all levels of intervention and support (universal/primary, targeted/secondary, and intensive/tertiary). In addition to the provision of technical assistance in programming, a staff member from the department spends .25FTE designing and coordinating the evaluation of the Instructional Discipline Pilot Program and providing evaluative results for purposes of decision support around programming, practice refinement, and policy.

Another strong collaborative between KDMHMRS and KDE is a Memorandum of Agreement (MOA) which provides for the sharing of resources and joint training for children's mental health and children's public educational services. The focus of the SFY 2004 MOA between the SIAC and the Department for Education was two-fold: To expand school mental health service delivery expansion and to enhance collaboration between education and mental health on the state and local level. On-going training and technical assistance regarding Wraparound, school-based mental health services, as well as the annual Choices and Changes Collaborative Conference are supported by the MOA. These efforts will continue in SFY 2006 and there is an added item to ensure collaborative support for the work Transition subcommittee discussed in Criterion 1.

Chaired by the Division of Exceptional Children within KDE, the **Kentucky Interagency Transition Council for Persons with Disabilities** is made up of 22 state agencies, including KDMHMRS. Their mission is to facilitate the work of state, regional and local agencies as they assist young persons with disabilities (all types) in moving from school to community living and employment.
The **Kentucky Educational Collaborative for State Agency Children** (KECSAC) was established through legislation in 1992. KECSAC Advisory Group members include representatives from six

agencies, including KDMHMRS. KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act (KERA) are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs.

A cadre of individuals representing various child-serving agencies that assembled in 1999 to form the **Kentucky School Mental Health Coalition**. The Coalition membership includes representation from the following:

- KDMHMRS (Division of Mental Health and Substance Abuse)
- Department of Education
- Department of Juvenile Justice
- Center for School Safety
- Kentucky Educational Collaborative for State Agency Children
- Regional MH/MR Boards
- Kentucky Psychological Association
- University of Kentucky School of Nursing
- University of Kentucky Chandler Medical Center
- Health and Welfare Committee of the Legislative Research Commission
- Department for Public Health
- Cabinet for Families and Children
- Kentucky School Board Association
- Kentucky Academy of Pediatrics
- Private Child Care

Acknowledging the need to improve and expand mental health services traditionally offered in schools, the Coalition has as its mission the expansion of school mental health services across the Commonwealth.

Child Welfare

The Department for Community Based Services (DCBS) is now within the same Cabinet as KDMHMRS and Public Health so the opportunities for data sharing and collaborative planning may become easier as we work together towards common goals. There are currently activities underway to bring together the Children's Services Directors from the Regional Boards and the Service Area Administrators from the DCBS regions to discuss issues of mutual interest including emotional injury, case consultation and transitional planning.

Juvenile Justice

Juvenile Justice's new system of care has been extremely beneficial to a group of children whose needs are very complex, but there is a growing interest in reaching children at earlier stages of their involvement with the child welfare and juvenile justice systems. In particular, the Department for Juvenile Justice (DJJ) has reached out to contract directly with Regional Boards and Private Child Care Agencies for community-based services and juvenile sexual offender treatment. However, DJJ has also begun creating positions within of their own agency to provide mental health and substance abuse services for their especially difficult to serve youth (e.g., adolescent sex offenders). The rise in the number of youth committed to Juvenile Justice and the historic lack of comprehensive mental health services to children and youth in the juvenile justice system make this desire for earlier intervention even more urgent.

State-level work groups were established to review regional planning council reports and recommend state-level initiatives to the HB 843 Commission (discussed in greater detail in Section II of this document). The Children's work group, focusing on children's services and service gaps, consists of the State Interagency Council as its core membership and is staffed by the Director of the SIAC staff within the Division of Mental Health and Substance Abuse.

KDMHMRS and DJJ are also working together to compare their data and determine if there are assessment and outcomes measurement tools that might be shared. A small portion of last year's block grant dollars was be utilized for the Bristol Observatory to assist with some data analysis.

PERFORMANCE INDICATOR 1

Goal: To ensure that services for children are fully integrated and holistic.
Target: Increase to 78% the number of children who are attending school greater than 90 percent during the year.
Population: Children with SED
Criterion: 3
Performance Indicator: School Attendance

Value:	Percent
Numerator:	The total number of children in the IMPACT program who are attending school greater than 90 percent during the year as reported on the Educational Status Checklist, completed by the teacher.
Denominator:	The total number of children who are served by IMPACT during the year for whom the Education Status Checklist was completed by the teacher.

Sources of Information: Data from the IMPACT Evaluation System that the Department has had in place for over 10 years for children with SED who receive IMPACT services. Staff sets targets based on the corresponding year's IMPACT data and the Plan and Budget applications from the Boards (Forms 118, 122 &123) and knowledge of various factors that may impact the system.
This data is not very reliable at this time but the indicator will be folded into the revised IMPACT Outcomes System discussed elsewhere in this document.
Significance: This is considered a valuable indicator of the population served and it is a key indicator of child functioning and the philosophy that all children, regardless of disability are entitled to a free and appropriate education.

PERFORMANCE INDICATOR 2

Goal: To ensure that services for children are fully integrated and holistic.
Target: Increase to 70% percentage the number of children who experience a stable living environment during the course of the year (includes only those children for whom the data is collected).
Population: Children with SED
Criterion: 3
Performance Indicator: Home Stability

Value:	Percent
Numerator:	The total number of children in the IMPACT program who had no placement change and lived in a family setting during the year as reported on the Residential Living Environments and Placement Stability Scale (ROLES) completed by the Service Coordinator.
Denominator:	The total number of children who are served by IMPACT during the year for whom the ROLES was completed by the Service Coordinator.

Sources of Information: Data from the IMPACT Evaluation System that the Department has had in place for over 10 years for children with SED who receive IMPACT services. Department staff sets

targets based on the corresponding year's IMPACT data and the Plan and Budget applications from the Boards (Forms 118, 122 &123) and knowledge of various factors that may impact the system. This data is not very reliable at this time but the indicator will be folded into the revised IMPACT Outcomes System discussed elsewhere in this document.
Significance: This is considered a valuable indicator of the population served and it is a key indicator of child functioning and the philosophy that all children function better in a stable environment and in a family rather than institutional setting. Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

PERFORMANCE INDICATOR 3

Goal: To ensure that services for children are fully integrated and holistic.
Target: Increase the percentage of children who are involved with the juvenile justice system and who need mental health services to receive them by 1% (from 4 to 5%) over the 2004 actual percentage served.
Population: Children with SED
Criterion: 3
Performance Indicator: Juvenile Justice Referrals- Children with SED

Value:	Percent
Numerator:	The total number of children with SED who had a Primary or Secondary source of referral within the Justice System.
Denominator:	The total number of children who with SED who are served during the year.

Sources of Information: MIS data is utilized for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 118, 122 &123) and knowledge of various factors that may impact the system.
Significance: Assessment and treatment for children involved in the justice system is imperative to addressing their needs and lowering delinquent and criminal behavior patterns among youth.

Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

ACTION PLANS
True collaborative planning and sharing of resources is difficult at best, but with the commitment Kentucky has experienced since the inception of the Kentucky IMPACT program and the creation of the SIAC, it has become a reality at the state, regional and local level. Constant nurturing of the relationships and the resulting creativity has made it successful in benefiting the children and families of Kentucky. Entering into formal Memoranda of Agreement has proven very valuable as well. Just like a written service plan with goals and objectives where all team members take on tasks to achieve mutual goals for the child and family, so it works for stakeholders working towards mutual goals.

Last year, the Department contracted with the Bristol Observatory to compare data of the Regional Boards and DJJ and learned that the estimated rate for shared clients in SFY 2004 was 4.77%. This is not an unexpected percentage but does validate estimates of state planners. Continued analysis of these data bases is being considered. DJJ has recently initiated a collaborative effort to once again bring child serving agencies together to discuss ways to improve referral paths and treatment resources for youth with mental health and child welfare issues.

Successes of Youth Transitioning to Adulthood services initiatives include the involvement of the adult services community with transition-age adolescents, reduced caseloads for Service Coordinators serving this population (which allows them to focus on transition issues), and improved collaboration

with the school-to-work programs implemented as a part of the Kentucky Education Reform Act. KDMHMRS is currently represented on a state level "Transition Core Team" which created and offers on going technical assistance to Regional Interagency Transition Teams (RITTs). The eleven RITTs, with Special Education Cooperative's Transition Facilitators as lead are meeting regularly to identify and address gaps in services to youth transitioning to adulthood.

- **State Objective C-3-1:** Further develop partnerships between mental health and the Kentucky Interagency Transition Council for Persons with Disabilities and the Kentucky Transition Project at the University of Kentucky's Interdisciplinary Human Development Institute to address transition issues of youth with SED.

Comments from the Mental Health Planning Council meeting on August 18, 2005:

Comment: Why is the juvenile crime rate down over the past 5-10 years? (asked in response to report of Juvenile Crime rate report that was shared with the Council).
Response: (by staff and DJJ Council member representative): the expansion of the following services; early intervention programs, diversion programs and locking up serious offenders, keeping kids in school rather than expulsions, and improved assessment and follow up programs.

Criterion 4: Targeted Services to Homeless and Rural Populations

The plan provides for the establishment and implementation of outreach to and services for, such individuals who are homeless. The plan also describes the manner in which mental health services will be provided to individuals residing in rural areas.

GOAL: To improve services capacity to persons who are homeless or who reside in rural areas of the state.

INTRODUCTION

Under this criterion, services provided by Regional Boards to children with SED, who are homeless or who reside in rural counties (within regions) of the state will be addressed. Thus, current activities regarding each of the two components Homelessness and Rural are discussed below, offering detail from a regional and state perspective. Related goals and action plans for the components are discussed collectively at the end of Criterion 4.

Component 1: Homelessness

REGIONAL PERSPECTIVE

Many Regional Boards do not continuously identify the living arrangement status of all children served and efforts remain ongoing to improve tracking. However, there are Regional Boards that have services targeting homeless or near homeless youth. The outcomes measurement system of the children served in the Kentucky IMPACT program are tracking living arrangement of those children. Five of the fourteen Regional Boards have specialized case management services for homeless youth. There are agreed upon protocol and priority referral policies in several regions. These are primarily relationships between Regional Boards and homeless shelters or other programs that specifically serve women and children who may be homeless or at risk of homelessness (e.g., children aging out of foster care, families seeking to escape domestic violence situations).

STATE PERSPECTIVE

Estimates are that 12,467 persons are homeless each day in Kentucky. According to the 2001 Homeless Survey conducted by Morehead State University, the most common rural homeless is a single woman, age 35, with two children. She has a high school education but did not graduate. She is Caucasian and most often a victim of domestic violence. It is important to have an understanding not only of those homeless on any given day, but those who are “at-risk” of becoming homeless. The Kentucky Council on Homeless Policy has decided to focus their efforts on prevention as a key to reducing the number of people who will experience homelessness in Kentucky and are currently in the process of developing and implementing a statewide prevention plan.

Component 2: Rural

REGIONAL PERSPECTIVE

Using the definition of Standard Metropolitan Statistical Area, and information from the 2000 Census, Kentucky has 27 counties considered urban and 93 considered rural. Approximately 44% of the state’s population resides in its 93 rural counties.

Rural communities often have fewer staff and resources to provide mental health services. It is important for rural mental health agencies to develop collaborative agreements with primary care physicians, senior citizens, church groups, and government agencies. Rural case managers have been resourceful in assisting persons with a severe mental illness in identifying their needs, as well as meeting these needs through the identification and development of local resources, and are critical linkages to formal and informal services and supports in rural Kentucky. Several actions by the Kentucky General Assembly have increased the types and numbers of mental health professionals who

can be Qualified Mental Health Professionals and created licensure for mental health counselors. The KDMHMRS will continue to work with rural communities and other entities in these activities including addressing shared federal, state, and local funding, shared and cross training, and bringing all stakeholders together at the state and local level to strategize best practices.

STATE PERSPECTIVE

The two most common barriers to mental health services in rural areas are the isolation of families who have a child with an emotional disability and limited public transportation. Isolation can be partially attributed to the geographic distance between neighbors, but may be more closely associated with the heightened stigma associated with mental health services in rural areas and the difficulty of ensuring confidentiality and anonymity in a small, closely-knit community.

Limited public transportation contributes not only to service access problems, but also increases the cost of services. KDMHMRS and Kentucky Medicaid allow Regional Boards to recover transportation costs as an allowable service delivery cost. Additionally, Kentucky Medicaid clients can receive direct reimbursement of transportation costs. The Human Service Transportation Delivery Program pools existing public transportation funds including Medicaid non-emergency transportation. A total of sixteen transportation regions statewide operate 24 hours a day/seven days a week with a single broker or broker/provider established in each region. Consumers access transportation services through a toll-free phone number. When no other source of funding is available to IMPACT clients, wraparound funds may be used to pay transportation costs, or if appropriate, costs to repair or secure an automobile.

Telepsychiatry networks that extend throughout Eastern Kentucky have been developed by Bluegrass Regional MH/MR Board and the Department of Psychiatry at the University of Kentucky. These networks deliver consultation and direct services to children and their families who are unable to travel. They also allow for “expert” consultation assistance to rural providers. (Refer to map of Telehealth Networks of Kentucky in Adult Criterion 4.) Likewise, telemedicine technology has enabled closer communication among regional mental health administrators and state personnel in the implementation of a federal grant which is serving to improve access and service capacity in three Appalachian regions in Eastern Kentucky.

The advantages of establishing a teleconferencing capability across rural areas are well known. Due to difficulties in recruiting qualified medical and clinical staff to work in more rural areas, teleconferencing can be used to extend staff coverage from a central site to outlying rural clinics and other service sites. Specialized services (e.g. therapists who are fluent in sign language) could be effectively extended through the use of teleconferencing.

Simplified Access to Commonwealth Service provides resource access via the Internet. Consumers, family members and providers can access the website at www.KyCARES.net and obtain information on any number of physical health and behavioral health services.

One strategy to address rural access problems is the recruitment and development of family support staff, who are parents of children with severe emotional disabilities. These parents are responsible for facilitating a regional network of parent-to-parent support and advocacy, which provide informal connections between parents to supplement kinship networks.

A third distinct problem is the difficulty of recruiting staff to work in the rural areas, which limits the capacity to expand and create alternative, non-traditional services. This is also discussed in Section II of this document as well as, in Criterion 5 of this Section. KDMHMRS is also involved with the implementation of a HRSA grant recently awarded to Eastern Kentucky University. Grant objectives specifically address cultural competency of the workforce in this Appalachian area of the state.

While the three problems of isolation, transportation and workforce are common to rural areas, each rural community has its own unique problems because of cultural, geographic and social differences. Thus, the strategies to address them must be collaborative among local, regional and state level stakeholders.

PERFORMANCE INDICATOR 1

Goal: To improve services capacity to persons who are homeless or who reside in rural areas of the state.
Target: Serve at least 46% for those children who reside in rural areas.
Population: Children with SED
Criterion: 4
Performance Indicator: Penetration Rate--Children with Severe Emotional Disabilities who reside in rural areas of the state.

Value:	Percent
Numerator:	Number of children with SED, served by the Regional Boards, who reside in rural (non-MSA) counties.
Denominator:	Five percent of the 2000 Kentucky child census who reside in rural (non-MSA) counties.

Sources of Information: MIS for actual number served and Department staff sets targets based on the corresponding year's Plan and Budget applications from the Boards (Forms 118, 122 &123) and knowledge of various factors that may impact the system. University of Louisville's Data Center is the source of MSA versus non-MSA Kentucky counties.
Significance: This is considered a valuable indicator of the population served and it is representative of the steady increase in demand for services in rural areas. The targets for last year and this year are modest due to the recent (and potentially continuing) changes in which counties of the state are considered rural (non- MSA) versus non-rural.

Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

ACTION PLANS
Building on the strengths of rural communities and collaborating with other child serving agencies is seen as the best strategy for addressing mental health needs of children and families in rural areas. By truly listening to families as they express needs and preferences for service delivery, planners are learning to build on local resources like schools and community colleges and community centers where they exist to address the multiple and often complex needs of children and families.

- **State Objective C-4-1:** Offer technical assistance to regions to improve tracking of homeless youth in the KDMHMRS information data system.
- **State Objective C-4-2:** Incorporate best practices for rural service delivery into existing KDMHMRS sponsored training events and technical assistance meetings with program supervisors (e.g., Mental Health Institute, Choices and Changes Conference, Children's Services Directors and Local Resource Coordinators Peer Group meetings).

Comments from the Mental Health Planning Council meeting on August 18, 2005:
There were no comments for this Criterion.

Criterion 5: Management Systems

The plan describes the state's financial resources, staffing, and the training of mental health service providers (including providers of emergency services) that are deemed necessary for plan implementation. The plan also describes the manner in which the state intends to expend the mental health block grant for FY 2006.

GOAL: To ensure that there are adequate financial, staffing and training resources to enhance the children's system of care in the state.

INTRODUCTION

This criterion addresses three critical components of the overall management for implementing the system of care that serves children with SED and their families. These components include: Financial; Workforce; and Training. As it is with many other states, Kentucky struggles to maintain and improve performance with serious financial constraints and workforce shortage issues. Thoughtful and collaborative planning is key to moving the system forward in the face of such challenges.

Offered below is discussion about the current status of the three components for this Criterion. Goals and planning strategies are again offered collectively at the end of the Criterion under Action Plans.

Component 1: Financial

REGIONAL PERSPECTIVE

Regional Boards have been hard hit financially in the past year in several salient ways. Included are:

- Moderate funding cuts from the Department (approximately 2.5%in SFY 2004 and an additional 2.5% in SFY 2005);
- Frozen Medicaid rates for key services, including Case Management;
- Increases in costs to provide health insurance for their employees; and
- Increases in the percentage employers must pay towards retirement plans.

STATE PERSPECTIVE

This marks the third year for Kentucky's revised "flexible funding" Plan and Budget application process. As described in Section I of this grant application, Regional Boards are required by statute and contract to provide a core array of services and are held accountable to selected performance indicators for their Children's Systems of Care, but are given autonomy (where possible) in how funds are distributed based on regional priorities. There were no new appropriations from the Kentucky General Assembly specific to children's services, in the 2005-2006 biennium budget proposal.

SFY 2006 CMHS Block Grant Allocations for Children by Type of Service

The following table illustrates how the CMHS Block Grant funds are being allocated for services to children with severe emotional disabilities in SFY 2006
by the components of the array discussed in Criterion 1:

Component	Block Grant Amount
Family Involvement & Support	$144,640
Clinical Services	$1,411,849
Service Coordination	$139,963
Systems Interface	$131,675
Other (may Include training, etc.)	$89,754
Total SED	**$1,917,881**
CMHS Block Grant Funds allocated to Regional Boards for services to either Adults or Children ($162,445) are not included in the above total.	

SFY 2006 Funded Entities – Children's Services

The table below shows SFY 2006 CMHS Block Grant funding by funded entity.

TABLE A	
Region/Contract	Amount of Children's CMHS Award for SFY 06/FFY 05
1 – Four Rivers	$67,603
2 – Pennyroyal	77,227
3 – Green River	81,671
4 – LifeSkills	109,346
5 – Communicare	98,609
6 – Seven Counties	453,040
7 – NorthKey	151,690
8 – Comprehend	54,030
10 – Pathways	168,164
11 – Mountain	69,486
12 – Kentucky River	88,904
13 – Cumberland River	95,974
14 – ADANTA	69,644
15 – Bluegrass	332,493
TOTAL	$1,917,881
Funds allocated to provide MH services For either Adults or Children (not included above)	$162,445

These entities will be funded with FFY2005 and FFY2004 carryover consistent with priorities of the Mental Health Services Planning Council and the Department's plan and budget process.

Component 2: Workforce

REGIONAL PERSPECTIVE

In the SFY 2006 annual Plan and Budget applications from the Regional Boards the following staffing patterns were reported:

- All but one region has a designated Children's Services Director;
- There are 1,345 staff assigned solely or at least 50% (of their time) to children and youth programs/services, with a range among regions of 10 to 400;
- Included in the 1,345, there are 39 child psychiatrists (with at least one year of specialized child training). Additionally, there are some regions that utilize residents working under the supervision of child psychiatrists and there are some adult psychiatrists serving older adolescents (not counted in the numbers above);
- There are 239 Service Coordinators statewide, with a range among regions of 5 to 39;
- There are 63 full-time and 162 part-time Therapeutic Child Support staff statewide;
- All fourteen regions have a designated Early Childhood Mental Health Specialist for mental health services for children age birth to five years (other than their Children's Services Director); and
- Over 150 clinicians statewide have training and experience in serving children age birth to five years.

STATE PERSPECTIVE

KDMHMRS contracts directly with each Regional Board to provide direct services and each Board employs the actual service providers. Thus, human resource development activities for the Regional Boards and their staff by KDMHMRS have traditionally been indirect, focusing on staff training, technical assistance and the establishment of minimum qualifications and core training requirements for providers. The Department continues in these roles but also recently has taken on a larger, more direct role in addressing the shortage of behavioral health care providers in the state. KDMHMRS is collaborating with Regional Boards and colleges and universities, as well as other key stakeholders to develop immediate and long-term strategies to address the shortages of qualified behavioral health professionals in Kentucky. This is discussed in greater detail in Section I of this grant application.

The Olmstead State Plan Committee has been addressing human resource issues in their deliberations. The availability of trained professional and paraprofessional staff has critical implications for the successful transitioning of individuals to the community from institutions. Of particular concern is the supply of personal care attendants (for individuals with co-occurring physical disabilities) and the supply of residential support staff. Job profiles are currently being created for several positions within the children's community-based services arena to determine workforce needs to meet demands as outlined in the Plan.

Component 3: Training

REGIONAL PERSPECTIVE

Regional Boards reported the following in their SFY 2006 Plan and Budget applications with regard to training of staff:

- All fourteen regions provide specialized training (beyond training required of all agency personnel) for crisis services staff;
- Nine of fourteen regions report that they provide training for Emergency Services personnel. Each of these nine regions train Police, and two also train Fire and EMS;
- Most regions report that staff has regularly scheduled time for consultation with child psychiatrists and other specialists within their own agencies.
- All regions provide training to their Service Coordinators beyond the required certification training; and
- All regions take advantage of the funding available for specialized training in Early Childhood Assessment/Treatment for their designated Early Childhood staff. These Specialists are expected to further train other Board staff throughout their regions, as well as offer training and consultation to the staff of other child serving organizations (e.g., early childhood centers, educators).

Region	Child System of Care Training Needs as reported by Regions' Children's Services Directors
1	Staff continue to request additional training on maladaptive personality development. Also, the need for advanced instruction regarding substance abuse co-occuring disorders will need to be explored.
2	Medication issues, specialized diagnoses
3	Family enrichment, crisis intervention, dealing with homocidal/sucidial clients, dual diagnosis treatment issues, boundaries and ethical training
4	Currently planning documentation training. Therapy with young children is an ongoing issue.
5	Training needs center around the topics of assessment, diagnosis and treatment. At the top of mental health issues regarding co-occurring disorders and reactive attachment disorders. The agency will be targetting issues related to levels of care and GAF.
6	Evidence-based practices, Attachment Disorder, Functional Behavior Analysis, Early Childhood Intervention
7	Evidence-Based practices, co-occurring disorders, early childhood treatment, Aspergers/OCD,

	Tourettes; Attachment Disorder
8	Collaborative Use of PBIS model with community partners, Child Sexual Abuse Assessment and Treatment, Autism Assessment and Treatment, Cognitive Behavioral Therapy, Family Assessment and Family Treatment, and Effective Stategies for dealing with Disruptive Behavior Disorders and Learning Disabilities.
9/10	Staff continue to need training in family therapy, marriage counseling & group techniques.
11	Community resources for children and families, substance abuse assessment, co-existing disorders, techniques to increase family involvement, increasing societal de-stigmatization of mental illness, and laws pertaining to special education.
12	Staff requires more training in dealing with adolescents with mental health and substance abuse treatment needs. The service coordination staff needs to receive more training in an assertive continuing care model.
13	Crisis to Care training (Deescalation and therapeutic holds) Stress Diet Health and Fitness, Wraparound Process, Early Childhood Training, Co-occuring Disorders, Treatment Planning, Infection Control, Safety, CPR & First Aid, HIPPA, Domestic Violence, Risk Assessment.
14	Abuse and Neglect Training, Fetal Alcohol Syndrome training, Co-occurring Disorder training, Behavior Modification Training, and Cultural Diversity Training.
15	Family therapy continues to be a major push, dual diagnosis treatment approaches, services to children with Pervasive Developmental Disorder, Early Childhood Services and protocol-driven approaches to children's disorders continue to be the major areas.

STATE PERSPECTIVE

There are many training events provided to staff using KDMHMRS funds allocated to the Regional Boards. Most often, such training events are made available to staff from other regions and other child serving agencies. There are also training opportunities for Regional Board staff available through the Sexual Assault and Domestic Violence program within other state agencies within the Cabinet (e.g., training events on treatment for children affected by trauma and abuse, physical health issues, domestic violence, child welfare protocols, etc.).

KDMHMRS retains a small amount of children's block grant funds to support statewide children's training initiatives geared towards the needs of children's mental health services staff who serve children with SED, and their families. The Department conducts some of these events and some are those of other agencies/entities that the Department helps sponsor with staff and/or financial resources.

The following table displays the Children's training initiatives slated for SFY 2006:

Division of Mental Health and Substance Abuse Sponsored/Provided Training Events

Type of Training	Intended Audience	# of Participants Anticipated	Frequency/ Length of conference
*Mental Health Institute Pre-Conference on Medication Algorithms	Behavioral health providers and administrators, consumers and family members	Approximately 1,000 Approximately 300	Annually 2.5 days 9/27-29/05 9/26/05
*Kentucky School of Alcohol and Other Drug Studies	Behavioral health providers and administrators, consumers and family members	Approximately 1,000	Annually 4.5 days 7/18-22/05
*Service Coordination 101 Certification (required for providers)	Prospective providers of Children's Targeted Case Management services (IMPACT and IMPACT Plus)	Approximately 35 per session	4 times/ year 2.5 days each
Local Resource Coordinator Technical Assistance Meetings	Supervisors of children's Targeted Case Management service providers	Approximately 25	Quarterly
*Kids are Worth It! Conference	Behavioral health providers, teachers, advocates, police, attorneys and social	Approximately 500	Annually 8/31-9/2/05

(Co-Sponsored by DMH)	services staff		
*Question, Persuade, Refer (QPR) Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Varies depending on location across the state	At least four times per year
*Cultural Competency Training of Trainers	Current and prospective providers of Cultural Competency Training at the KDMHMRS operated or contracted facilities and Regional MH/MR Board staff and KDMHMRS central office staff	Approximately 20	Four times per year and upon request
Train the Trainers Suicide Prevention in the Jails	Jailers and Regional MH/MR Board staff	Varies depending on location across the state	At least two times per year
Deaf Awareness Trainings	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Ranges from 5-125 per session	Typically once per month and also on a PRN basis
TTY Assistive Listening Devices Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDMHMRS central office staff	Ranges from 5-125 per session	Typically once per month and also on a PRN basis
What Is Mental Health Training	Kentucky Association for the Deaf	Up to 200	Annually
Domestic Violence and Deafness Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Approximately 60	Annually
*HIV/AIDS Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDMHMRS central office staff	Ranges from 5-125 per session	Annually

*Denotes that Continuing Education Units (CEUs) are offered for these training sessions.

Mental Health Institute (MHI)

The annual Mental Health Institute serves as the major KDMHMRS training event for mental health service providers and consumers and family members. This statewide conference features approximately 60 workshops covering a wide variety of topics from Prevention, Treatment, Rehabilitation and Recovery, to Administration. The sixteenth Mental Health Institute will be held on September 26-29, 2005. The theme of this year's Institute will be "Promoting Recovery through System Transformation" and it will again focus on evidence-based practices.

Kentucky School of Alcohol and Other Drug Studies

The annual Kentucky School has traditionally been the premier training event for those working in the substance abuse arena but it too has grown to include a wider audience and a broader focus to include professionals from a variety of disciplines. There are intensive sessions on a variety of topics including Adolescent Substance Abuse and Co-Occurring Disorders.

Service Coordination Certification Training 101 (SC 101)

As mentioned previously, all targeted case managers serving children with SED must complete a required certification training within the first six months of their employment. This is true for IMPACT and Bridges Project Service Coordinators and IMPACT Plus Case Managers. A team of individuals has been convened to serve as "faculty" of this curriculum, including KDMHMRS, SIAC, and IMPACT Plus central office staff, IMPACT and IMPACT Plus field staff. The faculty has studied and refined the curriculum and seeks to continually improve upon the content and delivery of the information deemed most relevant. This group is enthusiastic about follow-up training and support for case managers and it is hoped that staff retention will be affected by the work they are doing. This faculty is also involved with the planning and refining of additional training for IMPACT and IMPACT Plus staff.

Cultural Competency Training

The Department sponsors cultural competency "train-the-trainers" sessions twice per year for interested Regional Board and facility staff. The training uses a curriculum first developed in SFY 1997, but continually updated. Additionally, two seminars, targeted for KDMHMRS central office staff and regional trainers, are also provided on an annual basis.

Training of Emergency Services Personnel

Each Regional Board receives funding from KDMHMRS to support decriminalization of the mentally ill services for children. In addition to assessment and evaluation activities with children, Board staff are responsible for educating emergency services personnel (the courts, peace officers, inpatient psychiatric facilities, Rape Crisis Centers, etc.) as to applicable statutes concerning involuntary hospitalization and how to access evaluation services on a 24-hour per day, seven days a week basis.
In addition to these statewide conferences and workshops, the Department uses these funds to provide scholarships (limited) for parents and Regional Board staff to attend events such as the Mental Health Institute or Choices and Changes. Funds may also be expended to support technical assistance meetings to support on-going and developing children's programming (e.g. Therapeutic Foster Care, Day Treatment).

With regard to the revised Plan and Budget process, the Department has attempted to balance flexibility with guidance to ensure Regional Boards' ability to endure increasing demands while experiencing minimal funding increases. Regional Boards have been engaged from the beginning in planning meetings regarding the revised process. Also, a Plan and Budget Orientation session was conducted for administrators who are charged with completing the applications.

CMHS Block Grant funds are subcontracted by the Department to Regional Boards based on an approved Plan and Budget. The Plan and Budget is the basis for the contractual agreement between the Department and Regional Boards to provide services that are consistent with fund source requirements, departmental priorities, service definitions and standards.

Regional Boards may also subcontract with an appropriate community agency to provide services. Such proposals must first be submitted to and reviewed by the Program Planning and Evaluation Committee of the Regional Board in accordance with their established subcontracting procedures.

PERFORMANCE INDICATOR

Goal: To ensure that there are adequate financial, staffing and training resources to enhance the children's system of care in the state.
Target: To provide a slight increase ($328 in 2004 to $420 in 2006) in per capita funding for services to children with SED.
Population: Children with SED
Criterion: 5
Performance Indicator: Per Capita State Mental Health Expenditures – Restricted Children's Spending

Value:	Percent
Numerator:	Sum of KDMHMRS allocations to Regional Boards restricted to services for children with SED.
Denominator:	Five percent of the 2000 Kentucky child census.

Sources of Information: Allocations as designated to each of the Regional Boards and review of their reported expenditures at year end. Not all regions have submitted their financial implementation reports in time for incorporation in this report.

Significance: This is considered a valuable indicator of the resources available to meet an ever increasing demand for services. The amount available to serve Kentucky's children is well below the national average.
Please see Appendix A for completed reporting tables of the Performance Indicators in the requested format.

ACTION PLANS
KDMHMRS continues to keep abreast of workforce development issues and strategies from other states and other professions (e.g. teacher shortages). Continued collaboration efforts among stakeholders is considered key to better align the needs of Regional Boards with the requirements of the professional licensure boards, and the curriculum used at the universities and colleges with behavioral health degree programs. Exploration of techniques in marketing of the field, web-based learning, and flexible and collaborative funding are strategies considered promising for Kentucky.

In an effort to enhance competency across the state, the Department continues to offer specialized "Training of Trainers" (TOT) concerning cultural competency for staff of Regional Boards and facilities. Additionally, the Department includes cultural diversity topics in all major training events held throughout the year.

- **State Objective C-5-1:** Secure funds from all available sources (federal and foundation grants, state general funds, training and research grants, etc.) to encourage the implementation of evidence-based practices across the state.
- **State Objective C-5-2:** Assist regions with developing evidence-based treatment protocols for specific mental health disorders and co-occurring disorders in children and youth.
- **State Objective C-5-3:** Support the establishment of a sustainable suicide prevention effort, steered by a stakeholder group that improves public awareness, has a training component and is research driven.

Comments from the Mental Health Planning Council meeting on August 18, 2005:
Comment: Council member offered corrected information regarding changed name of entity (due to state government reorganization).
Response: Staff will ensure name and address are correct for the Office of Vocational Rehabilitation.
Comment: Need increase in IFBSS funding.
Response: Comment noted. (This statement is included in the plan under Child Criterion 2).